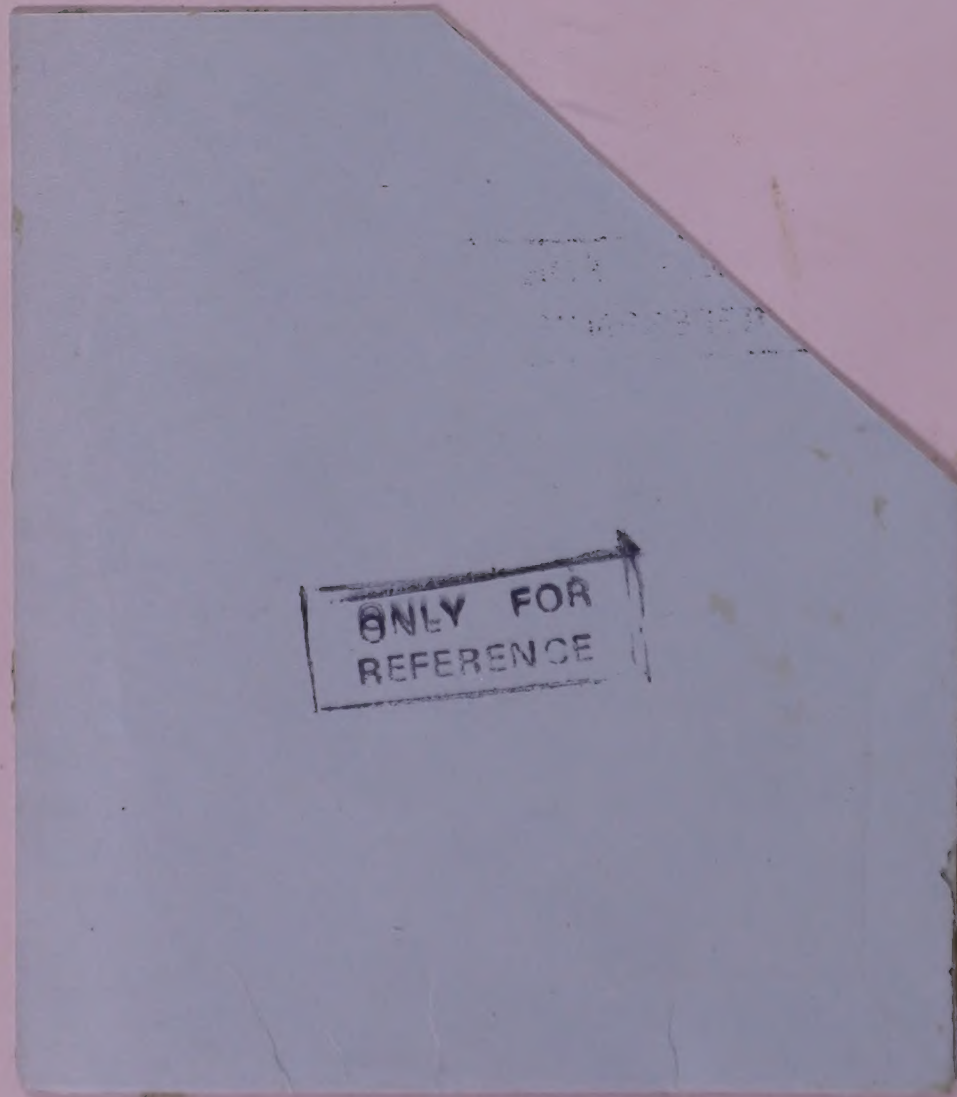
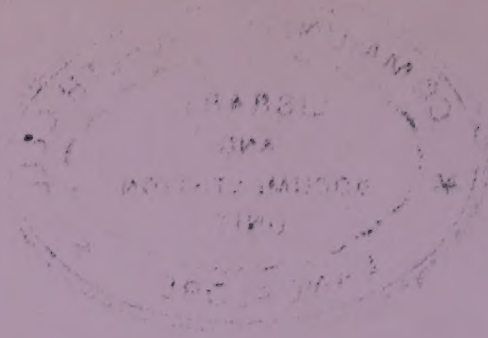


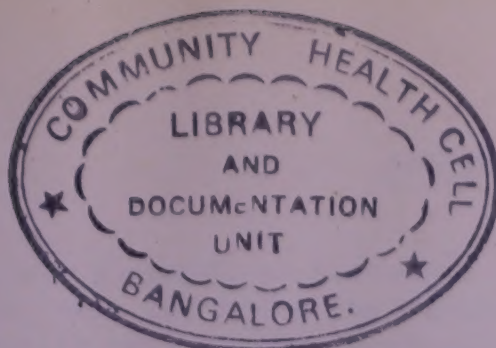


**A Manual For The  
Managers Of  
Community Based  
Primary Health  
Care Projects**





CMAI, 1987



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CMAI  
N. Delhi

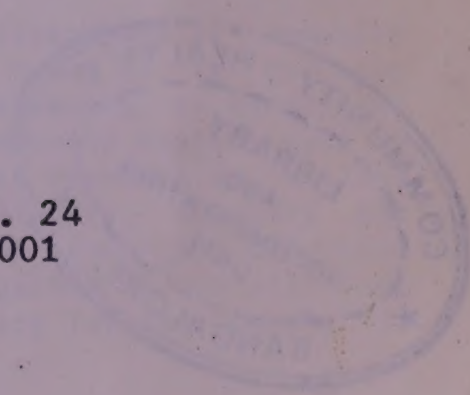
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HEALTH CELL

THE GREATEST NATURAL RESOURCE THAT ANY COUNTRY CAN HAVE, IS ITS CHILDREN. THEY ARE MORE POWERFUL THAN OIL, THEY ARE MORE BEAUTIFUL THAN RIVERS, AND FAR MORE DETERMINED THAT THE WORLD SHALL EXIST.

-DANNY KAYE

PREPARED BY : CMAI  
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INDIA





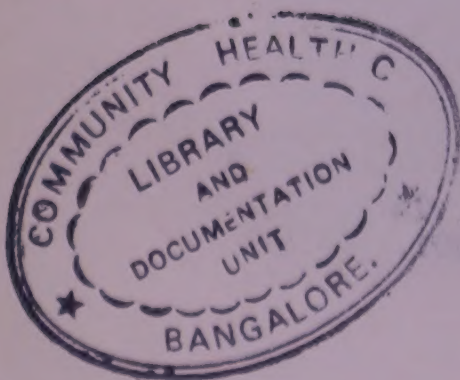
### ACKNOWLEDGEMENT

We express our thanks to the authors and publishers of various resource materials we used in preparing this manual. The list of resource materials we used are given separately.

C.M.A.I.

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FORWARD

It gives me great pleasure to introduce our Community Based Primary Health Care programme and to write the Forward for the manual for the Project Managers who are to work in the institutions that take up this scheme.

CMAI is committed to community health which includes meaningful community based primary health care that works with and for people. It is our desire to help people to help themselves so that they can meaningfully contribute to their own health and development. At the same time, we want appropriate low cost, relevant health care services that can make a difference in the health status of the community concerned. Our approach through Community Based primary Health Care is to reduce infant mortality rates, birth rates and childhood morbidity and mortality. Our emphasis is child survival so that every child born in the communities we serve has a better start in life. Our integrated package of resources for the same is referred to as FIONA (Family Planning, Immunization, Oral Rehydration Therapy, Nutrition of Infants & Vitamin A prophylaxis). We believe that there must be measurable change in some of the health related indicators. In order to make this programme Development Advisory Services that would give technical and other assistance to members who take up this scheme. It is also our desire to train key people who will be associated with the running of the programme in the member institutions. These project managers and field supervisors are thus extremely important to the success of this whole CMAI programme. They need the appropriate attitudes, skills, knowledge and expertise that can make them effective agents of change and leaders in community health work. I hope that this manual will play some small, yet significant, part in this process.

We in CMAI would like to thank our Consultants Dr. Sylvia Babu and Dr. Dasan Benjamin for their help in the preparation of this manual. We also put on record the hard work of our Assistant Training Co-ordinator, Dr. Bimal R. Charles who has worked closely with our Consultants and others to get this manual ready. Many people have been involved and it is difficult to record our appreciation to all, but, I would like to mention Mr. N.C. John who has worked in typing and with the computerization that has helped considerably. Yet, this manual is a means to an end and it is our desire to help our Project Managers and Field Supervisors to get on with the work in the field. They are thus to use this Manual as their reference and guide and to adapt and adopt it in the field.

In the final analysis, the appropriate policies and philosophies of community health cannot be adequately taught - they are caught - and it is for the people who use this manual, both the trainers and the students, to understand this process. Thus all of us who are concerned with Community Health, need to be personally committed to the values and spirit of this approach to health. We need to build healthy communities where justice, dignity, equality and health abound. Our desire is to facilitate a sense of community and team spirit amongst the trainees and the workers so that together we are all part and parcel of one great movement to make health a reality for the people of India.



CMAI is committed to helping its members to look at the larger issues of health and social justice where our programmes, assistance, schemes and training must all contribute to this goal. We believe that there must be an abundant life - "life in all its fullness" for the people of India. We hope that our programmes will give leadership and be an example for others. At the same time, we can share our success and failures with others.

We have great hopes in our Community Based Primary Health Care Programme and wish all those involved in it every success as we get on with the job. May God guide and lead us in this process.

Dr. Daleep S. Mukarji,  
General Secretary - CMAI.



## INTRODUCTION

This Manual focuses mainly on Child Survival in keeping with the goal of the community Based Primary Health Care Programme of Christian Medical Association of India. Our aim is to focus on the launching of low cost and widely applicable child survival measures, which can yield a quick and tangible pay off in lower rates of sickness and death and therefore reduced financial cost and anguish to families.

The manual does not deal with measures aimed at Socio-economic development of the Community which must be undertaken along with the provision of basic health services, in order to achieve Health, in its fullest sense. Measures aimed at improving literacy, organisation of co-operatives, income-generating schemes etc. are all a part and parcel of any programme aimed at improving health. However our primary intent is to encourage our institutions to move away from hospital based provision of health services to a community based approach, where the hospital continues to provide care for problems referred to it by the community.

In order to achieve this, our hospital need to become involved in the planning, implementation and evaluation of community based services. Our Institutions need to listen to the people and help them to help themselves in promoting and maintaining health. Child survival and other health measures appropriate for meeting health hazards in a community should be adopted and implemented within the frame work of the Primary Health Care approach.

In compiling this manual, we have used the best available materials on the subjects covered; a list of the books, periodicals and journals used is given in the list of resource materials used.

For easy reference, the manual has been divided into five sections with each section dealing with a specific topic.

The manual also gives guidelines for the CHVs Training. The information you get from different chapters will help you in teaching the CHVs. You may use material from other sources also for this purpose.

This manual is to be used during your training programme and you can add additional informations you get during the training, from your colleagues, journals etc.

A list of Resource materials you can avail of from different sources is given.

Annexures are provided as additional information.

It would not have been possible to produce the manual without the cheerful assistance of several of the CMAI office staff. Our thanks to Mr.N.C.John, Computer Assistant, Mrs.Maryann Vyland, Miss Shobha Mategaonker, and Mr.Anil. We are also extremely grateful to Dr. Ronald Seaton, Dr. Abel Rajaratnam, Dr. George Joseph, Ms. Sujatha de Magry and to the Area Managers of the CMAI for their valuable comments.



Needless to say, the continuous guidance and encouragement from Dr. Daleep S. Mukarji, General Secretary, CMAI, was most invaluable.

This manual is meant for you - The Project Manager.

This manual may not give guidance or answers to all the problems you come across in your work. Your suggestions to improve this manual are most welcome.

We have enjoyed working on the preparation of the manual together. We hope you will benefit from using it in the field. Do feel free to keep in touch with us.

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## SECTION I

### JUSTIFICATION OF THE COMMUNITY APPROACH

THIS SECTION INCLUDES

1. DISCOVERY KIT
2. COMMUNITY BASED PRIMARY HEALTH CARE







## DISCOVERY KIT

### An Introduction to the discovery kit

This discovery kit is designed to provide you with an opportunity to Discover aspects of the causes of ill health and underdevelopment (which are often only vaguely understood) and possible ways of finding solutions. The materials used in this Discovery Kit assume a fairly basic awareness of broad health and development issues i.e. it is assumed that you know that the general roots of ill health lie in disregarding the interrelationship between a multiplicity of factors that promote and maintain health.



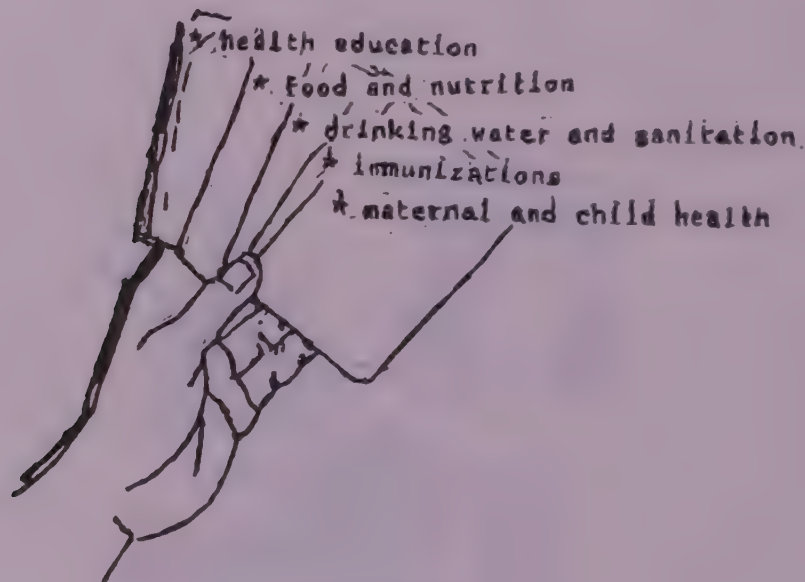
The primary objective is for you to feel empowered by discovering that groups and programmes all over the world are dealing with existing health and development problems in innovative and effective ways. Alternative approaches are increasingly being used to provide some curative preventive and promotive health services for all hopefully by the turn of the century. (Health for all by 2000 A.D. Alma Ata declaration 1978). In the Alma Ata declaration primary health care was declared to be the basis of achieving the goal of Health for all. The Principles of primary health care are clearly defined in the declaration as

- \* equitable distribution
- \* community involvement
- \* preventive and promotive approach
- \* appropriate technology and
- \* multisectorial approach



The components of primary health care include a crucial introductory phase including:

- \* health education
- \* food and nutrition
- \* drinking water and sanitation
- \* maternal and child health including family planning
- \* immunizations
- \* early diagnosis and treatment of minor ailments



We must be careful however that our efforts do not stop with this introductory phase. Health in its fullest sense cannot be achieved without developmental activities designed to generate community involvement. Sufficient safeguards must be included to ensure equitable distribution of resources and services.

It is obvious in a large country like India it is not possible to tackle all problems with the same intensity simultaneously. Therefore we will have to choose the most sensible and cost effective alternatives from among various possible approaches. There is general agreement that it is worthwhile to deal with population control, and the task of assuring the health and survival of children already born. The effort to ensure child survival is not only good for ensuring a healthy future generation but is also likely to provide the motivation to accept the small family norm and so contain run-away population growth.

Government already has existing programmes incorporating these components special emphasis being given to child survival by programmes such as ICDS (integrated child development services). The CMAI is proposing to launch a FIONA programme for vulnerable population groups) (Family welfare; Immunization; Oral rehydration; Nutrition; A Vitamin A prophylaxis).



You too have within your reach the means to change the conditions that foster illhealth and underdevelopment all of us are able and active learners-given the appropriate knowledge and training. People do have skills and reasoning ability to solve problems when given appropriate information with which to work. You have the capacity and opportunity to train the health manpower necessary to work in and with the community so that health for all becomes a reality. Our abilities as individuals and our responsibilities as citizens involved us all in promoting ways to achieve positive changes for our communities.

#### Educational objective for this exercise

- (1) To discover that health is a "wholeness" encompassing relationships, life styles, social environment and physical illness
- (2) To identify some of the causes of illhealth and its relationships to poverty and ignorance.
- (3) To assess the relationship between existing medical facilities (manpower, beds) and infant mortality rate.
- (4) To recognise that hospital services today are largely dealing with problems which can be prevented by health education and other activities at community level (primary health care approach).
- (5) To identify possible and effective solutions for improving the health status of the community.

#### Aids for your own discovery of issues in health and development:

- (1) Abstract from 'working together for health
- (2) Case study on hypertension.
- (3) Case study on tuberculosis .
- (4) Antia's article
- (5) A chart of comparative statistics .
- (6) Towards a polio free Madras.
- (7) Your own hospital morbidity statistics.



## WHAT IS HEALTH ?

Before we start this lesson let us first define health.

- 1.1 Are you healthy? How would you define health write your definitions below.

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---

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- 1.2 Most people would start by saying that health is the absence of illness or disease. Yet there is more to being healthy than being without disease. Being healthy means complete physical, mental, spiritual and social well-being. So a healthy person is one who possesses \_\_\_\_\_ and \_\_\_\_\_

- 1.3 Is spiritual well-being part of health? See Mark 2:1-12. What did Jesus first say in v 5? "My son your \_\_\_\_\_"

---

- 1.4 Why did Jesus not just say "You are healed" as he said later in v 11? See v 9-10. Jesus emphasises here that spiritual healing is part of physical healing. So the paralytic man would not be fully healthy until his \_\_\_\_\_ were forgiven.

- 1.5 So our definition of health is "being in complete \_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_"

---

- 1.6 Let us look at a few cases:

- a. Ramiah lives with his wife and six children in a village in South India. he works as a bonded labourer earning less than Rs.5/- per day. The landlord is constantly harrasing him about not working hard enough, even though he works ten hours a day in the fields. In addition to this problem he is concerned about not being able to provide adequate food for his children.
- b. Sushila is the village dhobi. She is preganant with her fifth child she feels weak and tired and has swelling of her legs inspite of taking medicines she is unable to work.
- c. Laksmi is the wife of one of the rich landowners in the village. One day her only son fell into the well and drowned. Laksmi was talking to a friend and did not notice this. She therefore feels guilty about his death and has occasional spells of deep depression.



Which of these would you consider healthy?

(a) Ramiah [ ]  
(c) Lakshmi [ ]

(b) Sushila [ ]  
(d) None of them [ ]

We will now follow the "Branching Method".

- \* If you answered a - go on to Frame 1.7
- \* If you answered b - go on to Frame 1.8
- \* If you answered c - go on to Frame 1.9
- \* If you answered d - go on to Frame 1.10.

1.7 If your answer was (a) look again at the definition of health. Although Ramiah has no physical illness he is certainly not in a state of good social well-being. From this stand point he would be far from healthy. Just because he has no physical symptoms of illness does not mean that he is healthy.

GO ON TO FRAME 1.11

1.8 If your answer was (b) you are forgetting the usual emphasis of illness - the presence of symptoms. Most people would not consider her to be healthy because of her symptoms of weakness, tiredness and swelling of legs.

GO ON TO FRAME 1.11

1.9 If your answer was (c) look again at the definition of health. She may have no apparent physical illness but she is definitely not in a state of good spiritual and mental well-being. Her guilt feelings for the "sin" of neglecting her son keeps her from being healthy.

GO ON TO FRAME 1.11

1.10 Did you decide that non of them could be considered healthy? If so your view of health is in keeping with the definition given earlier. Ramiah is unhealthy because of his social condition. Sushila puttiah is unhealthy because of her physical illness. Lakshmi is unhealthy because of her spiritual and mental condition. All three need to improve their health but the process of improvement will be different for each.

GO ON TO FRAME 1.12

1.11 Remember, being healthy does not just mean the absence of illness. instead it means being in complete \_\_\_\_\_, mental, \_\_\_\_\_ and \_\_\_\_\_ well being.

You need to learn this definition of health.  
It is important for you to understand what comes later.

1.12. Tick below any of these whom you would consider to be unhealthy.

- a. ☐ A four month old child weighing 2.5 kg.
- b. ☐ A 60 year old man complaining of severe abdominal pain for several months.
- c. ☐ A new wife concerned about the large dowry which her family had to pay at her wedding.
- d. ☐ A 20 year old man with chronic cough and fever now coughing up blood.
- e. ☐ A 30 year old bonded labourer who is working 12 hours a day in the fields.
- f. ☐ A 3 month old child weighing 8.5 kg.
- g. ☐ A 2 year old girls with draining ear and fever of 104 degree.
- h. ☐ A 22 year old man being forced by a money lender to work a second job at night in order to pay back a loan of Rs.5000/-.

How many did you tick? If you ticked all of them you are correct.

1.13 Most people will have little difficulty in pointing out that (a),(b) (d) and (g) are examples of unhealthy people, with symptoms that are usually considered as pointers to ill-health. But what of the others? (c) is about a person who is not in a state of mental well-being. So she can be considered unhealthy. The bonded labourer in (e) is in a state of poor social well being; and therefore is not healthy. The young man in (h) is also in a poor social situation and so considered unhealthy. Many people may consider the baby in (f) to be healthy, as they feel that a fat, chubby baby is healthy. A baby or adult weighing more than the normal weight for their age and height is just as unhealthy as someone weighting less than he should.



1.14 Who do you feel should be expected to be healthy? From the list below tick those people who should expect to be healthy:

- (a) The rich [ ]
- (b) The poor [ ]
- (c) Members of the Christian Community [ ]
- (d) Those who live in nice houses in the cities [ ]
- (e) Those from small villages [ ]

1.15 You should have again ticked all of the above. HEALTH is a RIGHT for all. This means that it is something to which (all/some) people have a just claim. (Score out the wrong word)

1.16 No person of higher social standing, education or wealth has a greater claim on health than anyone else. Good health is not just something which Christians can expect from God. Good health is a R \_\_\_\_\_ for all people.

1.17 Yet not all people are healthy. Why do you think some people are less healthy than others?

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1.18 Although all people have an equal claim on health, not all are equally healthy. Some people have poorer health through ignorance of how to maintain good health. Others are less healthy because of poor environmental conditions - this includes a social climate which fosters social evils, - eg. dowry, alcoholism or drug abuse. Others because of hereditary illnesses etc. Yet by far the greatest reason for poor health is poverty. Give the four reasons for poor health:

- 1.
- 2.
- 3.
- 4.

1.19. The greatest reason for poor health is p \_\_\_\_\_. It is not merely the lack of money to buy medicines or refusal to seek medical advice. A poor person has difficulty in providing adequate nourishment for her family. So the body becomes (healthy/unhealthy).

1.20 Poverty does not allow for adequate housing and sanitation, and this results in more illness. Poverty and lack of education together contribute to ignorance of good health practices and so to more illness.

## WHAT IS HEALTH - continued

In the last lesson we began a study on health. Let us look further at the subject.

1.21 We defined health as being in complete and well-being.

1.22 But what about sickness? Is it a punishment from God? (Yes/No).

1.23 Ramesh and Sarita were proud parents. Their little boy Anand was just 3 years old and a delight to their whole family. Then one day Anand fell ill and soon died. Some friends of Ramesh and Sarita came to visit them from their church. Sarita began to weep and ask, "Why has God done this to me? Where have I sinned?"

Their friends were wise Christians and explained that illness was not a punishment that God sent to people. Sarita looked surprised. "No", said their friends. "God placed all the punishment that our sins deserved on his son Jesus on the cross. There is no need for any further punishment."

Did the friends say that the death of Anand was a punishment for Sarita's sins? \_\_\_\_\_

What reasons did they give? \_\_\_\_\_  
\_\_\_\_\_

1.24 Many people, including some Christians, believe that sickness and disease is a punishment sent from God upon them. Read John 9:1-5. Whose sin did Jesus say was responsible for the man's blindness? \_\_\_\_\_

1.25 We need to remind ourselves that when any sick person came to ask Jesus for healing, he never refused them. Infact, Jesus healed even those people who were thought to be suffering especially harsh punishment from God because they were lepers.

Jesus shows that God's will is that sickness (SHOULD /SHOULD NOT) be healed, and prevented in every possible way.

1.26 Jesus sent out his disciples to do what he did - to announce that the kingdom of God had come and to heal people. (SEE MATHEW 10:7-8). He sends his disciples how today to do the same. In healing people, and in helping them to live healthy lives, we are demonstating the good news of the Kingdom of God and commending to people the good news of the love of God.



What two things do we do when we heal people?

1. We demonstrate \_\_\_\_\_

2. We commend \_\_\_\_\_

- 1.27 As we have seen, a healthy life is not just a life that is free from sickness. It is a life in which we can participate fully in human society. Read Genesis 1:27-28. God here made man the steward of his creation. So a healthy life is one in which we can be stewards of God's creation and take part through our work in developing the earth as God's home for man.

According to this frame, how would you define a healthy life?

\_\_\_\_\_

\_\_\_\_\_

- 1.28 Paul gave as a pattern for human society the model of a human body. In a healthy body each member plays its own role so that the whole body can function well. See 1 Cor 12:14-26

Can the eye function without the hand? \_\_\_\_\_

- 1.29 Now look at Romans 12:4-8. This tells us that every person, however lowly or unimportant has a part to play and a "gift" which everyone else needs. Just as we need even our smallest toe to walk properly, so the whole of society needs every member to function properly. In the list below who do you think is needed in society?

a. The pastor [ ]

b. The postman [ ]

c. The sweeper [ ]

d. The Panchayat Chairman [ ]

e. The schoolmaster [ ]

f. You. [ ]

- 1.30 I hope you ticked all of the above. So one of our tasks in enabling people to live healthy lives is to enable them to discover and contribute their "gift" to the whole of society. What is your gift?
- \_\_\_\_\_

- 1.31 The model of the body also tells us that each member should use his gift for the benefit of the whole body. If the right hand said that it would only use its skills to benefit the hand, the whole body would suffer. It would not be able to write or even eat. (Look again at 1 Cor 12:26). Similarly if people who are clever, powerful or rich just benefit themselves, everyone else suffers. So in enabling people to live healthy lives we must encourage them to live as servants of each other and to seek the interests of all, including themselves. This was Paul's clear advice to the Philippian Christians "Look out for one another's interests, not just for your own" (Phil 2:4 - Good News Bible).

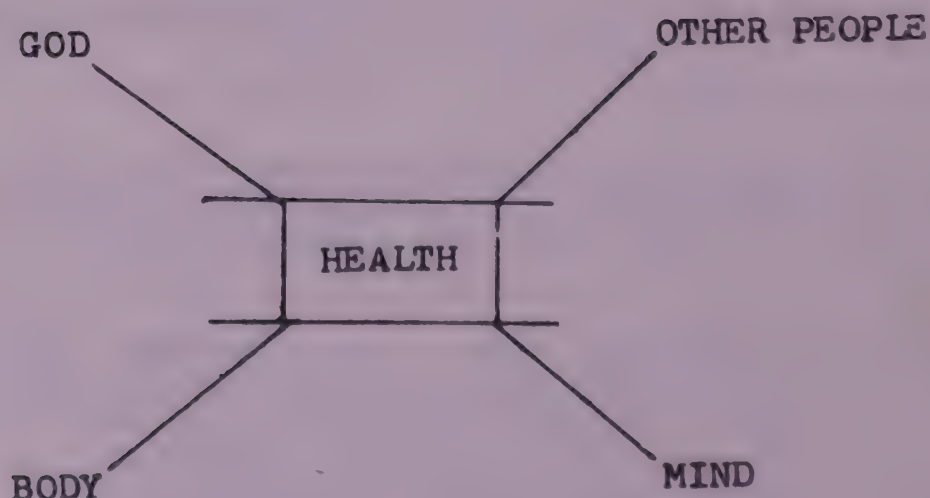
Whose interests should you look after?

a. ☐ your own   b. ☐ others   c ☐ both.

1.32 How are we to use our gifts for one another ? Jesus himself gave us the pattern. He contrasted his form of leadership with the form of leadership exercised by the politicians of his time. They exercised the rule by harsh domination, by forcing people to obey them in one way or the other. Jesus said that his disciples must not be such leaders. Read Mark 10:41-45. Jesus says they should be like him who, though he was their leader, s \_ \_ \_ \_ \_ them like a servant.

1.33 So we must encourage people to serve one another, to seek the interests of others in using the gifts, talents and resources that they have. This is specially important in the sharing of food, clean water supplies and in providing health resources for all the community. It is not natural for human beings to do this. We are naturally selfish creatures. This is why the transforming power of Jesus Christ is necessary if we are truly to enable people to discover how to seek the interests of others. In this way we will work fruitfully with them in building a healthy society.

Source: Working together for health - TAFTEE India (1984)





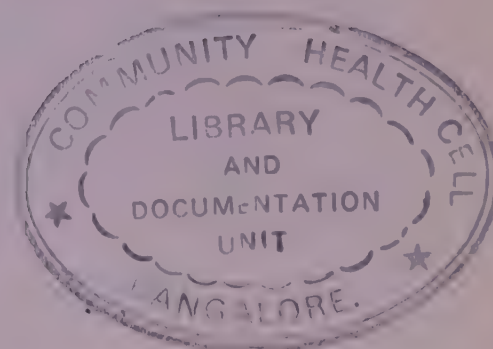
## 2. Case study on hypertension (blood pressure)

Mr Thomas is a business man who owns a profitable restaurant in the heart of a big city. His income enables him to live in luxury with all the comfort and style of the upper crust of society. However, he is plagued with symptoms of a stomach ulcer and also has very high Blood pressure. He is on medication for both these ailments with the best drugs (and therefore expensive) available in the market. In spite of this treatment there is scant relief from the burning pain in his abdomen and his headaches and dizzy spells. Mr Thomas is overweight, he smokes incessantly (foreign cigarette brands only) and drinks a quarter pint of Scotch whiskey daily. His physician is unable to help him in spite of repeated advice to cut down his consumption of alcohol and cigarettes. Mr Thomas' response to this advice is that both these habits are 'necessary evils' in his life because of pressures in his business and also because he is expected to entertain lavishly. Case histories such as this are not at all uncommon among the higher socio-economic group. Clearly, no medications exist to cure ulcers and/or hypertension which are caused and perpetuated by a life style which is injurious to the body.

(1) Is there a solution to Mr Thomas' problems?

If yes, what suggestions do you have ? If no, why not

(2) How many of these suggestions are possible in your hospital setting?



### 3. Case study on Tuberculosis (T.B)

Muthu lives in a slum with his family of six children, his wife and her mother. The living area for this household of nine people is one 8'x10' room and a small 2' x8' area which serves as a kitchen. All nine members sleep in the 8'x 10' room. Muthu earns his livelihood by hiring out 4 cycles which are owned by his landlord. Muthu is expected to pay the landlord Rs.10/- day for the privilege of hiring out the cycle which the landlord has purchased with his own funds. On good days Muthu can earn as much as Rs.20/- but on rainy days he sometimes has no customers to hire out the cycles. Muthu's wife Therisa works as a maid in two houses and earns Rs.200/- per month. Muthu has been diagnosed as having pulmonary tuberculosis and advised regular treatment for a minimum period of one year. However, the Govt. dispensary where he can get free medicines is a long distance from his house- the busfare to reach this dispensary is Rs 1.50 each way. There is no straight bus route, he must change into another bus to reach his destination. Also on one occasion, after he had made the effort to reach the Govt. dispensary he was asked to come back two days later as the medicines were 'out of stock'. So Muthu has been off treatment now for 3/12 - he is coughing more now and has chest pain which forces him to lie down. Because of this his 'cycle business' has deteriorated and he is unable to earn any money. The landlord is adamant about getting his Rs.10/per day. Muthu becomes depressed and turns to alcohol for relief from his frustrations. Soon he is demanding money from his wife to buy alcohol- if she refuses, he takes it from her forcefully, beating her up - for which he is always sorry. His family is not getting enough food - the youngest child aged 2 years is very weak and irritable and the doctor at a local clinic has diagnosed that this child also has Tuberculosis.

- (1) Given this case history, design specific interventions which you think would help to solve Muthu's problems.
  
  
  
  
  
  
  
  
  
  
- (2) Given that Muthu is 'cured' of TB, what other factors remains which will restrain him from achieving health.



#### 4. Responding to disease as people, and only they can - Antia's article

N.H. Antia who analyses the experience and results of a community health project in India - to indicate the practical relevance of the concept of primary health care. he argues specifically in relation to the basic capability of the community to treat and control diseases rampant in the country. We give here some relevant portions of his article published in "Future".

##### Disease profile:

According to the health statistics by the Central Bureau of Health Intelligence, Government of India, tuberculosis, tetanus, acute respiratory infection, gastroenteritis, measles, malaria, leprosy, poliomyelitis and filariasis comprise some of the major killing and maiming diseases that affect the people. This pattern is broadly true of most developing countries. This is by no means a comprehensive list for a host of other diseases like guinea worm, xerophthalmia, venereal diseases as well as medical and surgical emergencies, trauma and poisoning by pesticides and chemicals continue to take their toll.

For most of these, modern medical science has provided us with knowledge and technology for their prevention as well as for cure which is remarkably simple and safe as well as cheap.

##### Wrong response:

The response of the health services, which is generally guided by the medical profession, is for a vast increase in the medical and paramedical manpower and of drugs as well as of medical colleges, urban hospitals and more recently of Primary Health Centres. While the emphasis in the private sector is understandably confined to curative medicine this is also regrettably true to the public sector to a great extent. That part of the public sector which is entrusted with the preventive and promotive aspects and control of the major diseases and of the "primary health care services" scourges, namely tuberculosis, malaria, leprosy, filariasis and blindness. Most of these programmes have been in operation for several decades. Except for the eradication of small-pox and the control of malaria (which shows resurgence) these national programmes as well as the Primary Health Care centres have had little impact on the mortality or morbidity figures.

##### Faith in people:

This is clearly brought out by the experience in our own community health projects in Urban and Mandwa in the Maharashtra state as well as many similar experiments in India and other countries. While such experiments expose the social, economic and political factors which determine the health status of the people as well as of the health services, they also demonstrate that a considerable reduction in mortality and morbidity can be achieved even under the existing conditions.

The following table illustrates what thirty semi-illiterate village women working in thirty villages (30,000 population) could achieve in a period of five years when the chief input consisted of weekly discussions under the village tree and a very modest local supporting organizational and referral service:

	National Figures 1981 (a)	Mandwa Project 1982 (b)
Birth rate	33	15
Crude Death Rate	12.5	8
Infant Mortality Rate	127	74

#### Immunization:

Trible Antigen		92%
Polio	28%	67%
Tetanus Toxoid		78%

Source: (a) Central Bureau of Health intelligence, Government of India 1983.  
(b) The Foundation for Research in Community Health, Bombay.

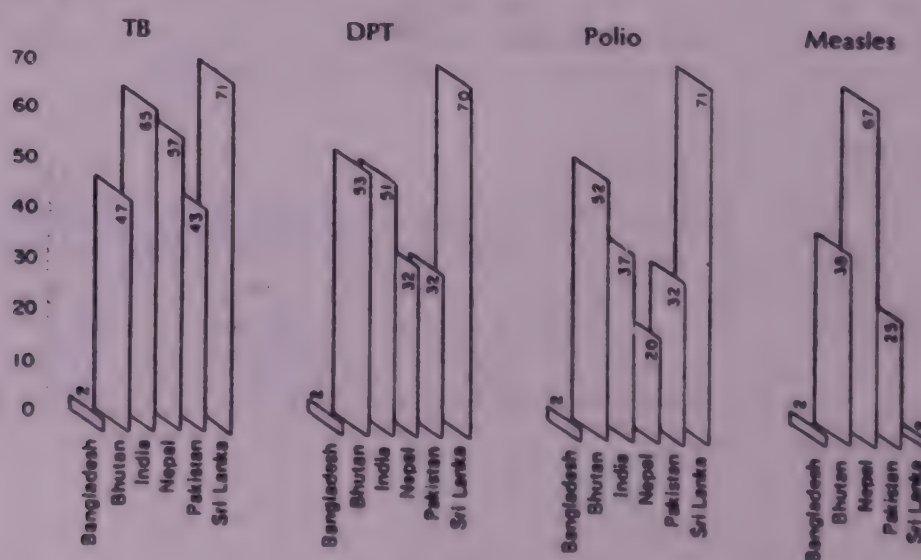
A baseline survey by the Tata Institute of Social Science revealed that the initial situation in Madras was no difference from similar rural areas.

#### Results speak

The results are more surprising because there were no inputs in nutrition, water supply or sanitation. There was lack of cocoperation from the private health servies and hostility from the public health services.

(Dr. N.H. Antia, FRCS is Director of the Foundation for research in Community Health , 84, Ar.G. Thandani Marg, Worli, bombay - 400 018. The Community Health Project in MANDWA, a village of Bombay was organized by the foundation among other activites.)

#### IMMUNIZATION percentage 1984-85





# 5. CHART OF COMPARATIVE STATISTICS - I

Indicator	India	Srilanka	China	Indonesia
1. Infant Mortality Rate (ages 0 - 1)	114.0	39	39	90
2. Life expectancy at Birth	54.1	67	67	52
3. GNP per capita (US\$)	260.0	320	310	580
4. Total population in millions (1985)	717.8	15.4	1027.5	156.7
5. Adult Literate% Males/Females	47/26	91/82	79/51	80/64
6. Primary school enrollement ratio Male/Female	98/69	85/84	*NA	100/95
7. Secondary school enrollement ratio Male/Female	39/20	50/55	*NA	36/24
8. % Mothers Breast Feeding at 3/6/12 months	93/60/50	88/82/60	*NA	98/97/83
9. % of children under five suffering from mild/moderate/severe mal. nutrition.	33/5	-	-	27/3
10. % - One year olds fully immunized BCG/DPT/POLIO	18/39/18	64/56/56	*NA	55/29/3

Source: 1. The state of the worlds children 1985 UNICEF  
2. Health Statistics of India 1985.  
3. Future - 18 & 19 - 1986

## Comparative Statistics - II

Indicator	India	U.P.	Bihar	Karnataka	Kerala
1. Infant Mortality Source :Sample registration system Registrar general of India.	110	150	118	69	32
2. Audults literate % Male/Female	47/26	39/14	38/14	49/28	75/66
3. Total Employment in Public - Private sector, total in lakhs/women in thousands	242.73/3056	26/178	16.20/118	12/162	11/369
4. Number of Instututions providing diploma in pharmacy Total Inst/no of seats	165/8075	9/430	4/280	34/1770	9/170
5. Doctor possessing recognised qualifications registered under state medical councils	2,97,228	26,502	21,621	23,470	14,251
6. No of Nurses(general) and pharmacists on the register of employment exchanges pharmacists/nurses	15918/7339	633/156	2455/431	144/200	589/1465

Source:Health statistics of India 1985.





Questions to consider after looking at the table on comparative statistics.

1. The low level of immunized children in India is an important cause of illness and death. What other factors affect their health and welfare of children.
  2. How does the number of doctors relate to infant mortality rate?
  3. Based on the information given what are some possible explanations for the statewide differences in statistics.
  4. Based on the information given what types of measures need to be taken in order to improve the health of people.
6. Towards a polio free Madras

As India prepares to attempt the immunization of all its children by 1990, smaller-scale programmes are yielding valuable experience of how to involve all organized resources in reaching out to the poorest groups. This year, one such campaign has also succeeded in controlling one major disease in one major city.

This year the city of Madras made an unprecedented attempt to contain polio by immunizing the vast majority of its children. Without this extraordinary effort as many as 1,000 of the city's children would have been permanently crippled by polio in the next twelve months alone.

What became known as the Madras momentum started in 1984 as a collaboration between the state government of Tamil Nadu and Project Impact - a coalition of organizations working to prevent disability.

After two pilot campaigns in slum areas, a citywide programme was mapped out for early 1985. The first task was to stock up on oral polio vaccine. With help from Indian business, Rotary International and the United Kingdom Save the Children Fund, the state ministry of health accumulated the necessary 600,000 doses during the early months of the year. To keep the vaccine cool until it was needed, three private companies volunteered their refrigerated storage space.

But as the pilot campaigns had shown, organizing the supply of immunization is often an easier task than organizing the demand. The next step was to inform all Madras parents of the three vaccination days and their importance.

First the slum-dwellers own community leaders were asked for their advice and help. Volunteers were recruited and the plans drawn up to visit each of the city's 1 million homes. On average, there was one vaccine centre for every five streets.

Among the volunteers organizers were schoolchildren, teachers, university and medical college students, local officials, child care workers, members of the Lions and Rotary clubs, and members of the general public. Touring films on polio were shown to thousands of slum-dwellers. The national radio and television networks ran advertisements, documentaries and panel programmes. Fleets of motor-driven rickshaws with megaphones toured the narrow streets announcing the vaccination days. A million handbills went up throughout the city. And on the streets, traditional puppet shows dramatized the war between polio and vaccine.

The Madras business community supplied ingenuity as well as cash to back up the campaign. Employees received notices in their pay packets stressing the importance of immunization, asking them to spread the message to friends and neighbours, and appealing for donation: the results were pinned up on company notice-boards. Immunization stickers were placed on telephone handsets in hundreds of small hotels and restaurants, which also offered their refrigerators for local storage of vaccine on immunization days. A vaccination 'advertisement' was rubber-stamped on outgoing mail in hundreds of commercial offices.

Between May and July, the majority of the city's children were immunized against polio, despite some falling-off in attendance. Even so, 94% of the city's children received the first dose, 88% the second, and 72% the third a coverage level that may be high enough to interrupt the transmission pattern of the disease and so protect even those who were not immunized.

Successful as it was, the Madras initiative raises the questions of how to sustain such initiatives year by year and how to reach children under one, the most vulnerable group. The campaign also tackled only one of the six vaccine-preventable diseases that strike at children's well-being. But as the project newsletter Moksha comments, "The creation, on a mass scale, of public awareness of the importance of immunization will further strengthen the existing expanded programme of immunization."

#### Questions on polio free Madras:

- (a) What are the elements that contributed to the success in this illustration.



(b) What steps do you think you can take to achieve a similar result in your project area?

(7) Your own hospital morbidity statistics (out patient or in patient)

Take a look at your own hospital mortality statistics and decide

a) How many of these disease could have been prevented by appropriate health education

b) How many could as well have been handled at community level at less cost?

c) If these disease were handled at community level what impact would have on your hospital?

The hospitals role in achieving the goal of "Health for all by the year 2000".

(a) Should hospitals be involved at all?

YES / NO.

If YES - what are the steps which hospitals must take to achieve this. (Check the appropriate steps or measures listed below).

i) Clarify their own aims and objectives.

ii) Design specific activities which will fulfill these objectives.

iii) Assess the impact of their services on the following:

- infant mortality rate
- birth rate
- death rate

iv) Invest in provision of specialised services.

### Assess ment

Multiple choice questions:

In the following questions

(1) Check (tick) the most appropriate answer

(2) Note that for some questions there may be more than one correct answer

I. Health is a state of well-being involving

- (a) relationship with God
- (b) Relationship with fellowmen
- (c) Relationship with our environment
- (d) Physical well-being
- (e) All of the above

II. Factors which help in the reduction of infant mortality rate (IMR) are :

- (a) Large number of hospital beds;
- (b) Sufficient number of doctors
- (c) Improvement of female literacy rates
- (d) All of the above
- (e) none of the above

III. The major factor which perpetuates ill-health is:

- (a) Inaccessible Government dispensaries/hospitals
- (b) Lack of essential drugs in government dispensaries
- (c) Poverty
- (d) Cultural beliefs.

IV. A state-wide desirable coverage of immunization cannot be achieved unless:

- (a) There is foreign aid
- (b) Superstitious beliefs are dispelled;
- (c) Children are forcibly immunised
- (d) There is political will and commitment



V. Primary Health care is

- (a) Treatment being restricted to minor ailments only
- (b) making hospital services irrelevant
- (c) practicing sub-standard medical care
- (d) comprehensive and multisectorial approach to health
- (e) none of the above

VI. Training in Primary Health care is essential for :

- (a) Medical superintendents
- (b) Nursing staff
- (c) Programme managers
- (d) field staff
- (e) consultants
- (f) all of the above
- (g) none of the above

In the following (CIRCLE) the correct response

VII. Peptic ulcer and Hypertension are diseases which can be cured completely by use of appropriate drugs alone ; True/False

VIII. Social evils, such as dowry, have no impact on physical well-being ;  
True/False

IX. Health is all its fulness can be achieved without any relationship to God; True/False

X. There is just and equitable distribution of existing medical technology  
True/False

## THE COMMUNITY BASED PRIMARY HEALTH CARE AND DELIVERY SYSTEM (CPBD)

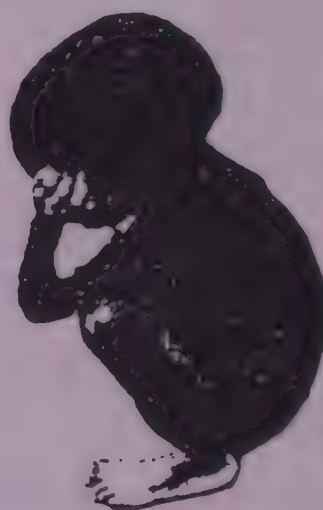
### CONTENT:

#### 1. Introduction:

In most of India for every 10 children born today one will die before the first birth day (IMR - 114) and 3 more will die before the 5th Birth day.

*We are guilty of many errors and many faults,  
but our worst crime is abandoning the children,  
neglecting the fountain of life.  
Many of the things we need can wait.  
The child cannot.  
Right now is the time his bones are being formed,  
his blood is being made,  
and his senses are being developed.  
To him we cannot answer 'Tomorrow'.  
His name is 'Today'.*

—Gabriela Mistral, of Chile



*His name is 'Today'.*

So:

- (1) OUT OF 10 CHILDREN BORN TODAY, ONLY 6 WILL CELEBRATE THEIR FIFTH BIRTH DAY.
- (2) MOST OF THESE DEATHS ARE PREVENTABLE.

These deaths are the result of:

- \*MALNUTRITION
- INFECTION
- DEHYDRATION DUE TO DIARRHOEA
- SHORT BIRTH INTERVALS
- INCREASING POPULATION



Vicious cycle of health care causing poor health



Aggravated by:

- inadequate and inappropriate Health Services.
- poverty
- unhygienic conditions

The Indian government has in a New Health Policy (1983) recognised some of the deficiencies in the health services and adopted and accepted the Primary Health Care approach in order to achieve Universal Primary Health Care "Health for all by the year 2000".

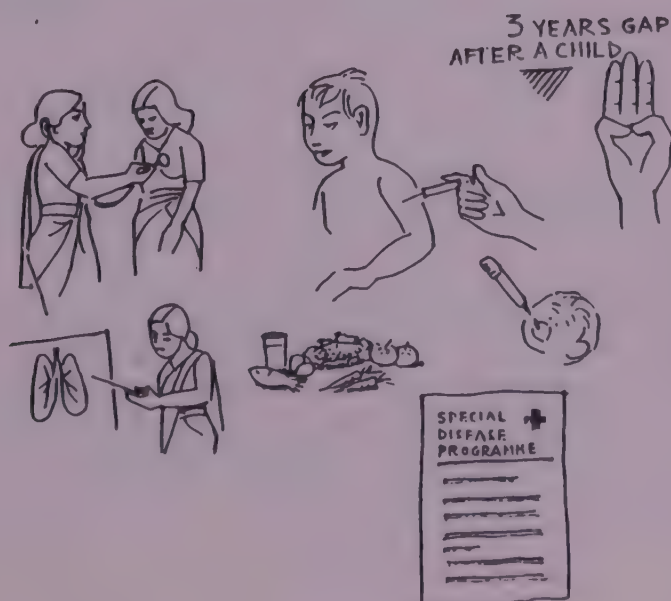
What is Primary Health Care?

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford.

It forms an integral form of both of the community health system and hospital based services of which it is the nucleus and of the overall social & economic development of the community.

The CMAI through its member institutions is committed to helping and assisting the government of India in achieving this goal, recognising that the components of primary Health care includes;

1. Women's Health
2. Child Health
3. Family Planning emphasising spacing of children
4. Low cost curative care
5. Special Disease programme
6. Health Education
7. Food and Nutrition
8. Drinking Water and sanitation



The Government of India in its National Health Policy 1985 aims at taking the services nearest to the door-steps of the people and ensuring fuller participation of the Community in the health development process. It has been recognised that if the quality of the lives of the people is to be improved, their health status must be raised. In this perspective, health development is to be viewed as an integral part of overall human resources development.

The National Health Policy points to the need of restructuring the health services on the preventive, promotive and rehabilitative aspects of health care and brings out the need for establishing comprehensive services to reach the population in the remotest areas. The programmes are being implemented through the fullest involvement of the communities.

Some of the major steps taken towards this direction are the following:

(i) To shift the emphasis from the curative to the preventive and promotive aspect of health care as well as to take services and supplies nearest to the door-steps of the people, the following changes have been brought about:

(a) It has been decided to establish one sub-centre for every 5000 rural population (3000 in Tribal and Hilly Areas) with one male and one female workers. 21135 new sub-centres have been opened during the four years, 1981-1984. The total number of sub-centres, as on 31-3-84 stood at 74307. A target of setting up 9071 more sub-centres during 1984-85 had been fixed by the planning commission.

(b) In place of the Primary Health Centre for every community Development Block it has been decided to have one Primary Health Centre for every 30,000 rural population (for every 20000 in Hilly and Tribal areas). 1726 New Primary Health Centres have been established during the four years, 1981-84. As on 31-3-84, the country had a total of 7210 Primary Health Centres. The Planning commission had fixed a target of setting up 197 more PHCs during the year 1984-85.

ii) To further the Primary Health Care approach and secure community involvement, a centrally sponsored programme is being evolved to train health guides selected by the community for every village or every 1000 rural population. 3.13 village Health Guides had been trained till 1-4-1984.

CMAI wants to work with and for people so that there may be "Health for All" CMAI accepts both primary Health care and appropriate referral and training centres and hospitals in its "BOTH AND" commitment to the health of the community (community health). CMAI recognises that it is mainly the government's duty and responsibility to provide health care services and yet we believe that voluntary agencies have a crucial role to play in this process. CMAI emphasises its commitment to community health - an approach that takes into consideration the needs and process. CMAI emphasises its commitment to community health - an approach that takes into consideration the needs and problems of the community and begins with a strong Community Based Primary Health Care System. Community



Health starts with people - the community - and is a process that recognises their right to health care. It enables or empowers them to work together to encourage people to take responsibility for their own health care services to be relevant, low cost, effective and acceptable to the people. It supports a referral system and states explicitly that there is a role and place for the hospital in community health.

Therefore the CMAI is assisting some of its member institutions in planning and implementing a Community Based Primary Health Care project.

## 2. The Community Based Primary Health Care project.

In a Community Based Primary Health Care Project the services are provided in the community. The community takes active part in the activities of the project and the community is involved in the decision making process.

In a hospital based Primary Health Care programme the services are provided by the hospital in the community. There is no community participation or community is involved in the decision making process.

For an effective Community Based Primary Health Care there should be a referral hospital for the backup services. The CBPHC projects can bring down the morbidity, mortality and the fertility rates. This is more appropriate for a developing country like India where for most of the people in the rural areas the hospital services are not available.

The essentials in this Community Based Primary Health Care are :

This covers a definite population. It is necessary that this population is surveyed to know their problems. The people from the community are involved right from the beginning.

The care provided should be appropriate, low cost and acceptable to the community. This should be available at the closest possible distance from their homes.

The priority is towards prevention promotion and maintenance of health.

The institution or hospital works closely with the peripheral community based project.

The community based project works with the Government and the other local agencies, traditional birth attendants and local practitioners to involve them in promoting health.

A community based project should always link development to its ongoing health activities.

## 2.1 Goals and Objectives.

### THE GOAL IS CHILD SURVIVAL

For purposes of this programme, child survival is defined as Survival of live born children till 2 years of age.

In order to achieve this goal we need to:

- (1) Ensure a "good start" by caring for the mother during pregnancy with special emphasis on her diet and immunization and education.
- (2) Ensure good nutrition so that the child can grow well and have the strength to fight infection.
- (3) Prevent diarrhoeal death with promotion and use of oral rehydration therapy.
- (4) Protect the child from the vaccine preventable diseases by immunization.
- (5) Encourage spacing between births so that the child can get the necessary food and attention.



How will you ensure every child born in your project area reaches his/her 2nd birth day?



You will need to have a clearly defined set of activities to achieve this. For this you will have to know the various facts that have an impact on child survival.

We will learn about these together. Once you have understood the facts you can then list specific activities which will help you to ensure child survival.

For example - You will learn Family planning is essential for Child survival.

Oral rehydration therapy can prevent most diarrhoeal deaths.

By implementing CHPHC, child survival can be ensured. However as a P.M. (Project Manager) you must have a clear idea of exactly what you want to achieve in your project area.

YOU WILL BE RESPONSIBLE FOR WRITING SPECIFIC OBJECTIVES FOR YOUR OWN PROGRAMME.

Examples of specific programme objectives are:

- (a) To have 30% of eligible couples using a method of contraception by the end of one year.
- (b) To immunize 50% of children against TB, DPT by the end of one year
- (c) To have less than 2% of children below 5 years suffering from 3rd degree malnutrition.

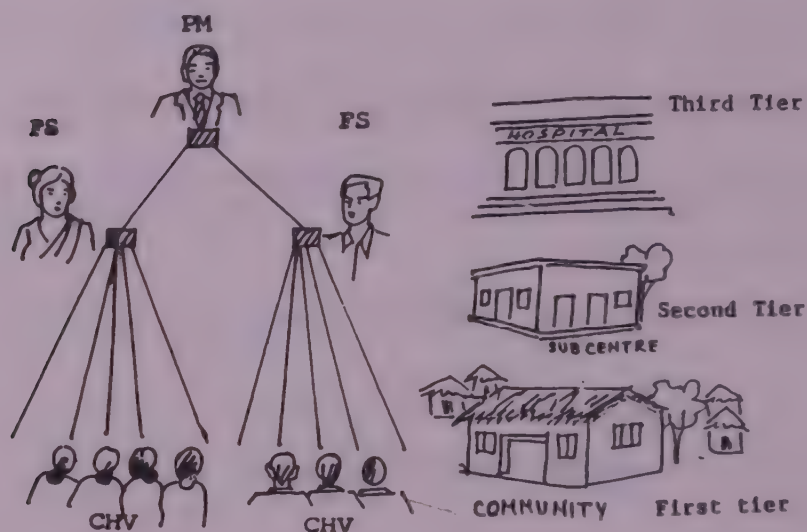
NOTE THAT

Programme objectives given above are:

- 1) SPECIFIC - i.e. address a specific problem.
- 2) RELATED to problem  
a specific segment of population.
- 3) MEASURABLE - 30% of eligible couples so that you know the exact performance expected.
- 4) TIME BOUND - at the end of one year - so you are clear as to the time in which to complete the expected performance.
- 5) FEASIBLE - i.e. can be achieved with the available resources.

## 2.2 Design - Organisational chart

The community based health care project is by definition based in the community. It provides health care services within a three tier system as follows:



**First tier:** The Community Health Volunteer, (CHV) a locally resident woman, selected by the community and trained to deliver primarily a set of health promotive services. One such person per approximately 1000 population (1:1000).

**Second Tier:** Sub-centre, health centre or primary health unit with 1 full time staff called Field Supervisor or Multipurpose Health Worker (FS) One such unit per 5,000 population.

**The FS:** One male and one female, could be ANM's, multipurpose health workers or other locally and appropriately trained personnel. The Field Supervisors are responsible for the training, supervision and support of the CHVs and to responsible for one sub centre.

**Third Tier:** The hospital

The staff of the hospital should visit regularly and support the field workers and the health programme.

People from the community will be referred to the hospital for specialised curative care and appropriate family planning and delivery services.

**2.3 Service:** The services provided by the programme includes,

1. Antenatal care - using locally trained midwives whenever possible.



## 2. Care of children in the first 2 years of life ensuring

### 1) Adequate immunization coverage

ii) Nutrition education for mother, family and community so as to have good growth of children.

iii) Adequate education in community and for mother on oral rehydration in the treatment of diarrhoea and dehydration.

3. Family planning services - offering variety of options for the community, both temporary and permanent method.

4. Health and Nutrition education.

5. Simple low cost curative health care services - using local herbs, systems and indigenous practitioner's practices where possible.

6. Special health care for local needs - TB, Leprosy, environmental sanitation, blindness prevention, etc.

## 2.4 Functioning of the Programme:

The CHV is the main link with the community and the health team.

As she performs her daily tasks she becomes the first point of contact between the system and the community; therefore her role is crucial.

You will need feed back from the CHV for planning and implementation of specific programme. e.g. There is no point in planning an immunization programme on the "festival" day.

CHV is a part time worker, yet she needs to know her community, visit her community regularly, collect information on the prioritised families and report to FS. She should focus her work on health education in promoting and maintaining the health of the people in the community.

The diary she maintains will be the major source of information used in reporting the progress of the work.

The field supervisors main responsibility is to support and monitor the work of the CHV.

By rotation, Field supervisor stays at the sub centre and visits the communities he/she is responsible for. His/Her main job during these visits is to support and encourage the CHV, check to see if required events such as births, deaths, have been recorded, pregnant women identified and to document these in her register.

All staff will have a monthly meeting where progress is shared problems discussed and reports written and plans made for next month.

2.4 FIONA - is one of the strategies for child survival.

F - Family Welfare

- play a crucial role in child survival
- DELAYING THE BIRTH OF THE NEXT CHILD as well as limiting the number of children are just as important as immunization in saving the lives of children.

I - Immunizations:

Protection against 6 major diseases can prevent unnecessary child deaths.

In India - EACH YEAR

- 2,30,280 die of neonatal tetanus (0 - 1 month of age)
- 200,000 die of measles.
- 2000 die of polio.

O - Oral Rehydration Therapy:

- 1.5 million children under 5 years die EACH YEAR of diarrhoea. 60 - 70% of these children die of DEHYDRATION
- These deaths can be prevented by prompt use of Oral Rehydration Therapy.

N - Nutrition:

- Only 15% of children below 5 yrs have normal nutrition i.e. 85% suffer from MALNUTRITION.
- 50% of women of low socio-economic group are anaemic.
- Much of this can be prevented by simple nutrition education.
- The new born children should be given the first milk (Colostrum) which protects babies from diseases. Breast fed children are healthy, suffer from less episodes of diarrhoeal diseases.

A - Vit A prophylaxis:

- 30,000 children go blind each year due to Vit A deficiency.
- THIS FORM OF BLINDNESS IS TOTALLY PREVENTABLE by giving Vit A and education about foods rich in this Vitamin.



## 2.5 Working with Government and other agencies.

Work with Government agencies wherever possible.

This means you should preferably get government approval to work in your community.

Advise your staff to cooperate and work along with government field staff.

You should be familiar with district development programmes (through the block development officer) which are going on in your area - get to know what procedures are required to obtain resources.

Make contacts with other departments, go to their offices, meet their staff, get to know them and find out what their responsibilities are: e.g. department of education, department of social welfare.

Utilise the resources of the anganwadi centre if one exist in your area. In many cases vaccines can be procured directly from the District Health Officer.

## 2.6 How to share this knowledge with your co-workers?

Once your team is selected, meet with all your co-workers to explain the overall goals of the programme.

Make sure each worker is aware of his/her role, responsibilities and relationships with the co-workers. Use the diagram of organisation to explain this.

- You may begin by initiating a discussion regarding accessibility of health facility, affordability of treatment modalities, difficulties in the existing health delivery system.
- EXPLAIN the Community Based Primary Health Care approach as a resource available in the community with back up and referral services at the subcentre and hospital.
- SHARE the overall goal of the project i.e. child survival.
- EXPLAIN the means of ensuring child survival through the services the project will provide - FIONA.
- EXPLAIN each worker's role and responsibility in the delivery of the services; discuss the job description and the role separately with Field Supervisors and CHVs.
- SHARE your role and responsibilities as manager of the programme.

## 2.7 SUMMARY:

The Community Based Primary Health Care Programme is a three tier system of health care delivery.

The CHV is the main provider of services in the community.

She is supported in her job by the Field Supervisor.



## SECTION II

### PROGRAMMES FOR CHILD SURVIVAL

1. POPULATION EDUCATION
2. FAMILY PLANNING
3. REPRODUCTION
4. CONTRACEPTIVE METHODS
5. VACCINE PREVENTABLE DISEASES AND IMMUNIZATION
6. DIARRHOEA AND ORAL REHYDRATION THERAPY
7. MALNUTRITION AND NUTRITION EDUCATION
8. PREVENTABLE BLINDNESS AND VITAMIN A

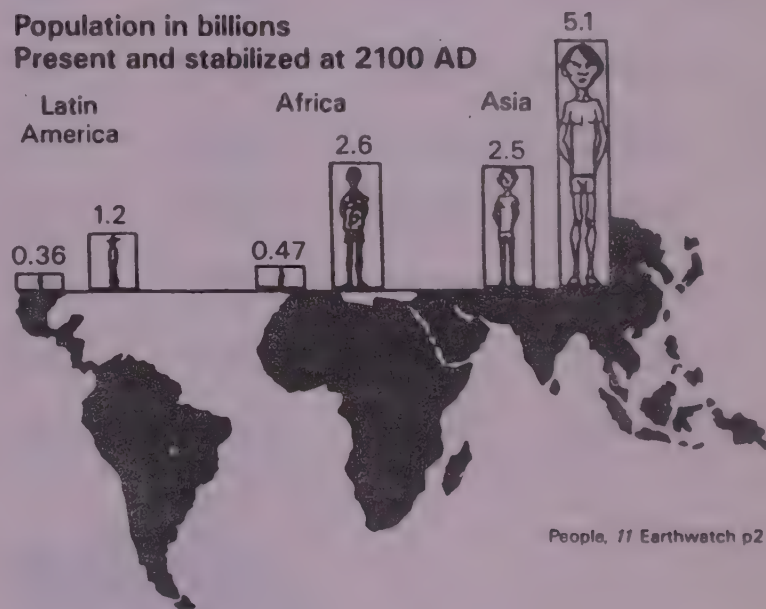
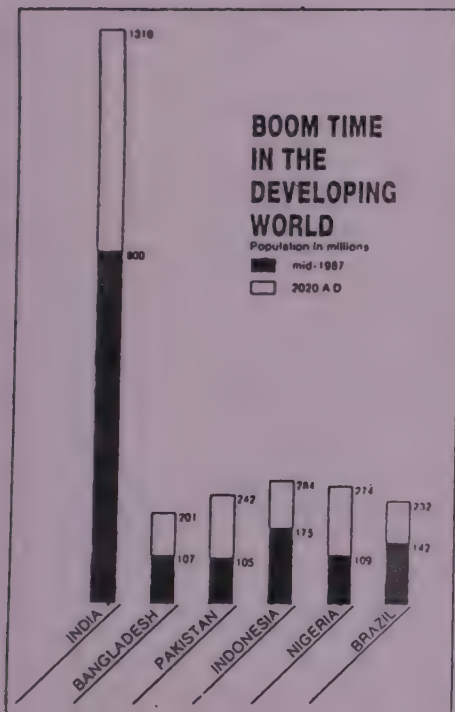




## POPULATION EDUCATION

### 1. What is population education?

- (i) Developing peoples awareness and understanding of population problems especially those faced by the family and community.
- (ii) Influencing people to change their attitudes, by realising their own responsibilities so that they can better deal with population problems.



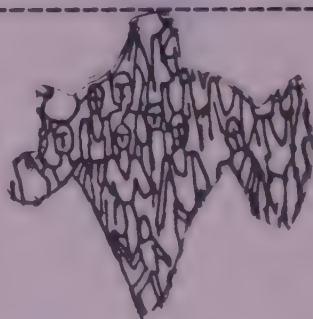
- (iii) Preparing people to make sound decisions and change their behaviour on:

- \* age of marriage
- \* number of children to have
- \* movement from villages into cities
- \* use of natural resources, forest, water, etc

## 2. Facts on the population of India.

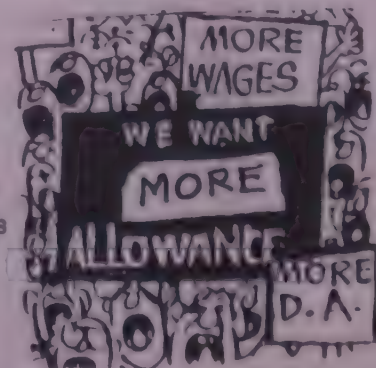
### TRENDS IN POPULATION IN INDIA 1901 - 1981

YEAR	Persons (000)	Males (000)	Females (000)	Sex Ratio (Female per 1000 Males)	Density of popu- lation per km square	% of Urban population to total population
1	2	3	4	5	6	7
1901	238396	120791	117359	972	77	10.84
1911	252093	128385	123708	964	82	10.29
1921	251321	128546	122775	955	81	11.18
1931	278977	142930	135789	950	90	11.99
1941	318661	163685	154690	945	103	13.86
1951	361088	185528	175560	946	117	17.29
1961	439235	226293	212942	941	142	17.97
1971	548160	284049	264111	930	177	19.91
1981	685185	354398	330787	933	216	23.31



In a Government of India publication entitled 'Population Problem of India', published in 1967 when the population of the country had already increased by 13 million since 1961, it was calculated that for this additional population there would be required:

12,545,300 quintals	more food
188,774,000 metres of	more cloth
2,509,000	more houses
1,026,500	more schools
3,072,500	more teachers
4,000,000	more jobs





(3) PERCENTAGE DISTRIBUTION OF POPULATION BY AGE-GROUPS 1971 AND 1981 CENSUS

Age Groups (years)	1971			1981*		
	Persons	Males	Females	Persons	Males	Females
(1)	(2)	(3)	(4)	(5)	(6)	(7)
0-4	14.5	14.2	14.9	12.6	12.3	12.9
5-9	15.0	14.9	15.1	14.1	14.0	14.1
10-14	12.5	12.8	12.2	12.9	13.1	12.6
15-19	8.7	8.9	8.4	9.6	9.9	9.4
20-24	7.9	7.6	8.1	8.6	8.4	8.8
25-29	7.4	7.2	7.8	7.6	7.5	7.8
30-34	6.6	6.4	6.8	6.4	6.3	6.5
35-39	6.0	6.1	5.9	5.9	5.8	5.9
40-44	5.2	5.3	5.0	5.1	5.3	5.3
45-49	4.2	4.4	3.9	4.4	4.5	4.3
50-54	3.7	3.9	3.6	3.8	4.0	3.6
55-59	2.3	2.4	2.3	2.5	2.5	2.5
60-64	2.6	2.6	2.6	2.7	2.7	2.7
65-69	1.3	1.3	1.3	1.4	1.4	1.5
70 +	2.1	2.0	2.1	2.4	2.3	2.4
All Ages	100.0	100.0	100.0	100.0	100.0	100.0

\* Excludes Assam and the figures are based on five percent sample data.

Source: Registrar General of India

- (1) DEPENDENCY: Since nearly half of the population cannot fully support themselves, they are dependent on the economically active to support them.

Young (0-15) + old (64 and above) is supported by people between 15 and 64 years of age.

- (2) MIGRATION: From villages to cities - note the increasing urbanisation.

- (3) CROWDING: Note the increasing population density shown in the tables

Note also increaing urbanisation resulting in overcrowded cities leading to serious problems such as poor sanitation and health, social problems etc.

- (4) How does population affect our lives?

#### BY DECREASING RESOURCES

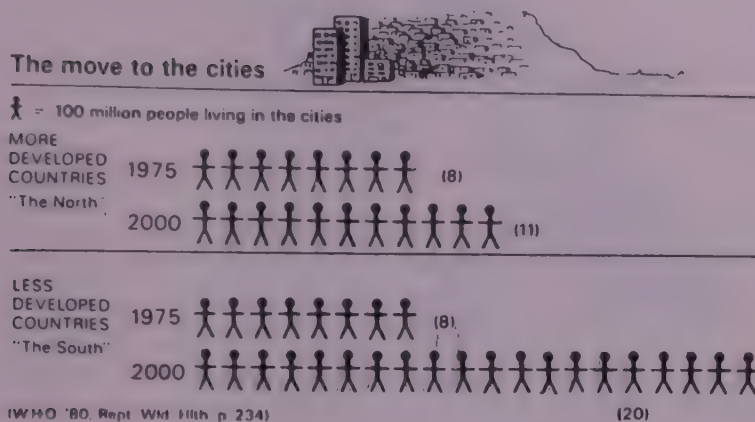
- \* destroyed forests - wood used for industry, housing, opening more land for agriculture, fuel



- \* soil erosion - as a result of cutting forest; rich top soils are being washed away.
- \* these lost soil are flowing into rivers often changing the course of these rivers and making the work of harnessing these rivers extremely difficult
- \* Less land available for agriculture.



- \* Inadequate housing
- \* movement from villages into cities



- \* fewer services and opportunities
- \* more unemployment

#### 5. What can we do about population problems?

- \* improve the income of families
  - population problems are not separate from other problems of life.
  - when family income improves people tend to have fewer children
- \* limit family size
  - marry later
  - practice family planning.

## FAMILY PLANNING

THIS FAMILY HAS MANY CHILDREN.



THIS FAMILY HAS FEW CHILDREN



What is family planning?

Family planning means

- to decide the number of children a couple wants to have
- to decide on the interval between two pregnancies
- to use a suitable method to prevent an unwanted pregnancy
- to assist couples who have no children due to infertility - to have them.

### ADVANTAGES OF FAMILY PLANNING:

#### 1. For maternal and child health

- 1.1. Prevents maternal weakness caused by frequent and repeated pregnancies
- 1.2. Prevents infant weakness caused by interrupted breast feeding and decreased care by tired mother and arrival of the next child.
- 1.3. Longer interval between pregnancies promotes healthy children because the mother has recuperated from the previous pregnancy.
- 1.4. Weak mother and weak children are pre-disposed to many diseases. FP helps them stay healthy and strong.
- 1.5. Mental health of the mother improves because she has less worries. Mental health of the child improves because he arrived when he was wanted hence cherished and loved.
- 1.6. Both the mother and the child have a better chance to survive.



Why don't parents plan their families?

Because of the following factors

- \* influence of our culture and the society in which we live
- \* our religious and personal beliefs
- \* level of education and knowledge
- \* level of family income
- \* knowledge of available methods and other resources such as follow up services and appropriate medical care

\* Government approach and strategy

As part of the new 20 Point Programme, the family welfare is to be pursued on a purely voluntary basis as a people's own programme. Our approach is to promote responsible and planned parenthood through a well designed strategy salient features of which are :-

- i) Adoption of the " Small Family Norm " is decided by the couples on an entirely voluntary basis.
- ii) Intensified efforts are being made to spread awareness and information about the small family norm through more effective and imaginative use of multi-media and interpersonal communication channels for disseminating group-specific messages.
- iii) A wide choice of contraceptives is offered to eligible couples under the cafeteria approach, and supplies of contraceptives are being increased and arrangements are made to make them available at the door-steps of the acceptors.
- iv) The programme is an integral part of planning for comprehensive development which covers correlates of fertility. In this regard, operational linkages have been established with other development Ministries/Departments at Central, States and field levels.
- v) Facilities and efforts for rapid increase in female literacy are being continually expanded.
- vi) Population education is extended to youth in schools and colleges as well as to those out of school. It forms an important part in workers education and training programmes conducted by Government Agencies and the organised sector.
- vii) Elected representatives of the people at all levels, grass-root level organisations like Village Panchayats, Mahila Mandals, Youth Clubs and Voluntary Organisations, etc., are encouraged to participate in this programme.
- viii) Enforcement of the law relating to minimum age at marriage for girls and boys is vigorously pursued.
- ix) Following an area specific approach, regions lagging behind in performance are given greater attention.

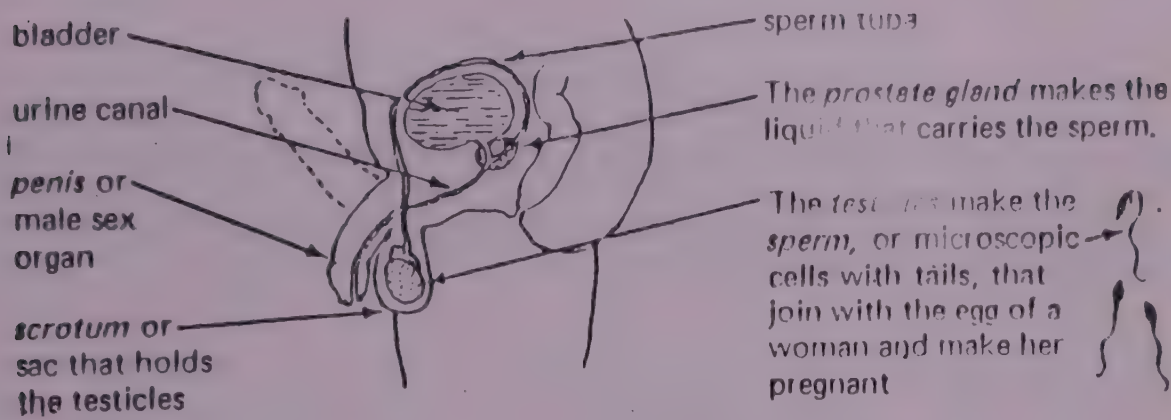
## MYTHS AND RUMORS

TRADITIONAL BELIEFS	ATTITUDE CHANGES NEEDED
<p>Children are Gifts of God</p> <p>Children are an economic necessity (to help in the field, watch the animals, take care of younger brothers and sisters).</p> <p>A man shows his <u>masculinity</u> (virility) by the number of children he has</p> <p>And more particularly because sons are required to perform the ceremonial rites at the death of the parents and also to continue the family name and inherit property.</p>	<p>This is true, but it is all the more reason why they should be cared for properly. Today this can only be done if there are few children in the family.</p> <p>Again this is true, but this can only be done successfully if they are healthy and well fed.</p> <p>This belief is not based on any true scientific or physical fact.</p> <p>While it is true that sons can provide security for parents in old age, and can inherit and work the land, daughters are equally capable of providing such support if given equal opportunity and rights</p> <p>Traditional attitudes and laws regarding social role of daughters and women will need changes.</p>
RUMOURS	FACTS
<p>If a man is sterilized, it means he is <u>castrated</u>, and he becomes very weak.</p> <p>Women who practice family planning may <u>die or become sick, and the methods do not always work</u> so they will have children anyway.</p> <p>Family planning causes the <u>death of the unborn child</u> which is a sin</p>	<p>Male sterilization does not involve castration at all, and in almost all cases the man maintains his full strength and ability to work and continue to enjoy sex.</p> <p>While no family planning method is 100% safe and effective, for the most part they are effective if <u>properly done</u> and practiced.</p> <p>If family planning is practiced correctly the child is never conceived so there is no death involved, so it is not a sin.</p>



## REPRODUCTION

### A. Male reproductive system & its function -



This consists of :

- 1) 2 glands called testicles
- 2) 2 tubes called Vas Deferens
- 3) 2 small bags called seminal vesicles.
- 4) A gland called the "prostate" gland which surrounds the upper part of the urethra.
- 5) 2 other very small glands which are below the prostate. These are called Cowpers gland.
- 6) The Penis which contains a tube called urethra. The Penis is also called the "male organ".
- 7) Externally, one sees the Penis and a bag which hangs under the penis. This bag is called "Scrotum". The 2 glands called testicles are in this bag. Part of the tubes called Vas Deferens is also in the Scrotum.

#### Function of Various Parts of the Male Reproductive System

As you read the functions of the male reproductive system, you will realise that many things are like the female reproductive system.

## 1. The Testicles

The 2 glands called testicles produce the male eggs. This is called SPERM.

They also produce hormones.

The production of sperms starts by the age of 11 years. In the beginning the sperms are not mature. By the age of 16 a boy has mature sperms (male eggs).

## 2. The tubes (Vas Deferens)

These tubes carry the sperms to the two small bags where they are stored.

## 3. The two small bags called seminal vesicles are for the storage of the sperms. They also produce a fluid.

## 4. The prostate gland.

This gland makes a fluid. The sperms need some way of moving forward to the vagina. The fluid made by the seminal vesicles and the Prostate make a fluid called "Semen" or "man's fluid".

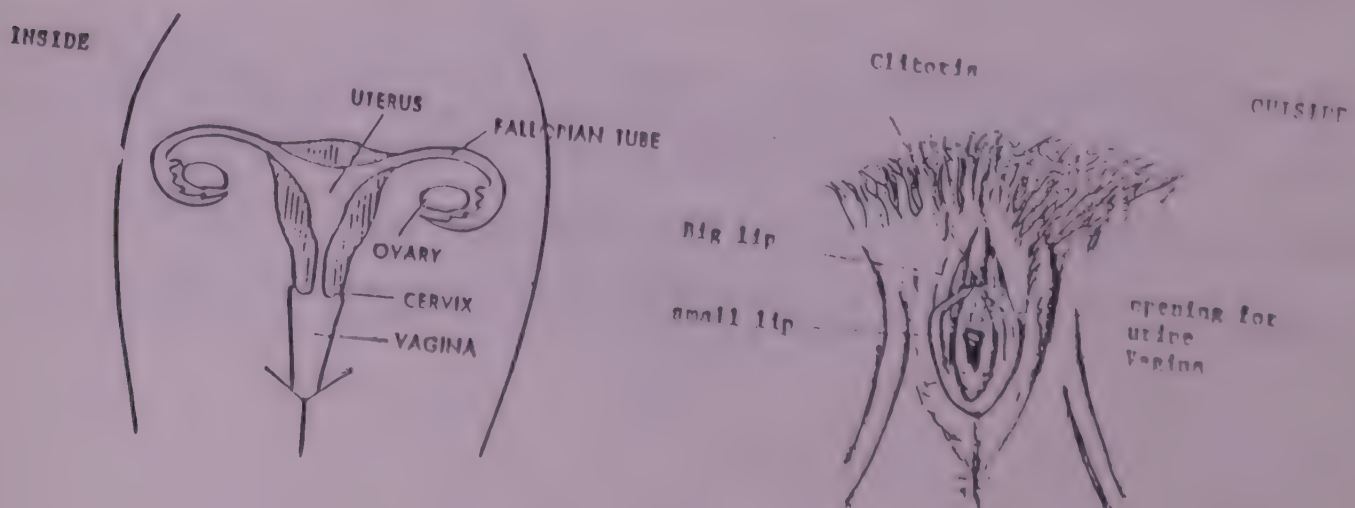
The sperms get mixed in this fluid and can move easily to the vagina.

## 5. The 2 small glands called the Cowpers gland also secrete tiny quantity of fluid at the time of sexual intercourse.

## 6. The Penis (the male organ) has two functions. It contains the tube called the urethra. The man passes his urine through the Urethra. The Penis is also the instrument that enters the vagina to deposit the sperms in the vagina. The penis has only one opening on the outside. The male urine and the male sperms pass through the same opening.

## 7. The bag called scrotum is for the protection of the testicles. It also keeps the testicles at the right temperature, for the production of the sperms.

## B. Female reproductive system and its functions





Female Reproductive system consists of (refer diagram)

1. Two glands (called ovaries)
2. Two tubes (called Fallopian tubes) they enter the womb, one on each side.
3. The womb (called uterus)
4. The vagina.
5. The outer part of the female reproductive system.

This is the part we can see. This has two "big lips", two "small lips", a small gland called clitoris and two openings. One opening is for passing urine and the other opening is the entrance to the vagina. The clitoris is situated above the opening for the urine and is wrapped in a fold of skin. (see diagram)

6. In the lower part of the two "Big lips" are two other glands, one on each side. They cannot be seen.
7. The female breasts are also considered a part of the female reproductive system.

#### Functions of various parts of the Female Reproductive System

##### 1. The Ovaries

These are the store houses for the female eggs. The eggs are present at birth but are not ripe. When a girl grows up the eggs begin to ripen. This happens between the age of 11-15 years. Once a month one egg ripens at a time and leaves the ovaries. Normally the Ovaries take turns to produce a ripe egg.

The female egg is called "Ovum". So the function of the ovaries is to ripen the female egg and release it.

When the egg leaves the Ovaries we say "Ovulation" had taken place. Ovulation takes place about 14 days before the monthly period starts. The ovaries also produce certain secretion "Hormones".

##### 2. The Fallopian Tubes

The Fallopian tubes are for catching the egg. Whichever ovary produce the the tube on that side catches the egg and moves it forward.

### 3. The Uterus (The Womb)

The womb is the place where the baby grows when pregnancy takes place. At the age when the ovary of a young girl begins to produce ripe eggs the inside walls of the womb begin to prepare themselves for pregnancy by making a spongy layer. The womb has an opening in the vagina. It is called the "Cervix" or the mouth of the womb.

### 4. The Vagina

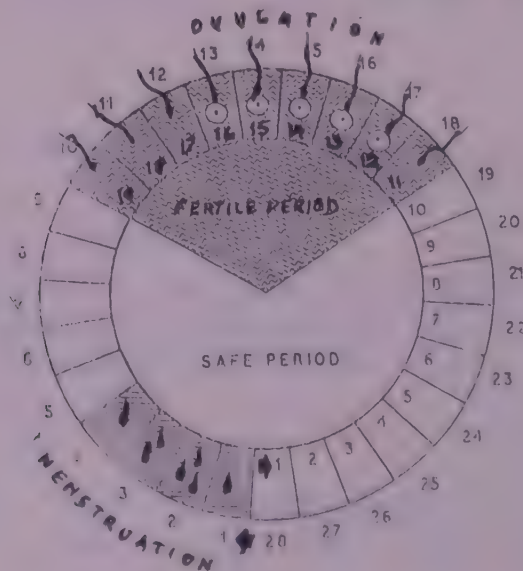
This is the way for the baby to get out. This is also the way that the blood comes out during the woman's monthly periods.

This is also the way by which man's eggs enter the woman's body to meet the female egg.

5. The outer part of the female reproductive system which we can see is mainly for protection of the openings and the clitoris. The clitoris is a very sensitive little gland. It plays a part in making the sex relations enjoyable.
6. The two glands in the lower part of the two big lips make tiny amount of a fluid which makes the vagina moist at the time of sexual relations.
7. The female breasts produce milk for the baby. They also play some part in making the sex relations enjoyable.

### 3) Menstrual cycle

Up to the age of about 12 to 14 years, the ovaries are not mature and the girl is not capable of bearing a child. From the age of about 12 the ovary starts shedding an egg every month. From this age the uterus starts developing a thick lining which is meant to receive the egg if it is fertilized, by a sperm. If the egg is not fertilized, it is absorbed and the lining which is no longer required is shed along with some amount of bleeding. This happens every month and is known as the monthly period or menstrual cycle.





#### 4. Conception -

The meeting of female egg(ovum) and male egg sperm is called pregnancy or conception

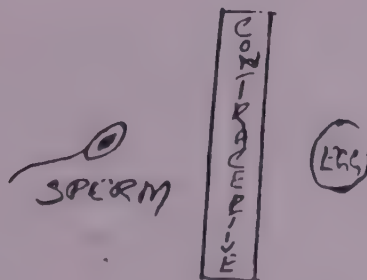


How does conception take place?

During intercourse the male inserts the penis into the vagian of the female and semen containing sperms are deposited in the vagina. From here the sperms move up into the uterus and tubes searching for an egg. If intercourse takes place at the time when the egg comes out of the ovary, the sperms can meet with the egg and can fertilize it. The fertilized egg is moved along the tube into the uterus where it buries itself into the thickened lining. The women is now said to have concieved or is pregnant.

#### 5. Contraception:

5.1 Meaning - Contraception means to practise a method to prevent an unwanted pregnancy.



5.2 Pregnancy can be prevented if,

- (i) The sperm cannot reach the ovum.
- (ii) The ovum is not released each month by the woman
- (iii) The fertilized ovum cannot attach itself to the wall of the uterus.

5.3 Contraceptive is the method used to prevent a pregnancy.

5.4 The purpose of using a method can be:

- a. To postpone a pregnancy for some time - This is called "spacing". This means that the couple wants a child but later.
- b. To prevent a pregnancy in future. This is called "limitation". This means a couple does not want any more children.



## CONTRACEPTIVE METHODS

### CONTRACEPTIVE METHODS FOR MEN

#### 1. Nirodh (condom)

This is a thin rubber sheath which is used to cover the penis just before intercourse so that spermatozoa are prevented from entering the vagina.

##### Advantages

- i. It is available free at the subcentre or from the male and female health workers, or at little cost from local shops.
- ii. No examination by a doctor is required before using the nirodh.
- iii. It is relatively simple to use.
- iv. There are usually no complications after use.
- v. It protects against the spread of sexually transmitted diseases.

##### Limitations

- i. It may tear or slip off if not used properly.
- ii. Without self-discipline, it may not be used every time.
- iii. The supply may be inadequate or irregular.
- iv. It may interrupt intercourse because it has to be put on after erection.

##### Instructions for the user

- i. It must be fitted on the erect penis before intercourse by keeping the tip pressed between the fingers.



- ii. The nirodh must be held carefully as it is taken out of the vagina in order to avoid spilling seminal fluid into the vagina after intercourse.
- iii. A new nirodh should be used for each sex act.
- iv. The used nirodh should not be thrown about indiscriminately but it should be wrapped in paper and thrown in the dustbin.

If this method is selected by a couple, give them a sufficient number of nirodh and inform the Field Supervisor (Male) so that he can follow up the use of the method.

## 2. Withdrawal (coitus interruptus)

If the couple do not accept any other temporary method of contraception and do not wish to undergo sterilization, the husband can be advised to use the withdrawal method. In this method the penis is withdrawn from the vagina just before ejaculation.

### Advantages

- i. No devices are necessary
- ii. No cost is involved
- iii. No prior medical examination is required

### Limitations

- i. It is unreliable as a contraceptive method
- ii. It can cause psychological disturbances in either the man or the woman
- iii. The sexual act is interrupted.

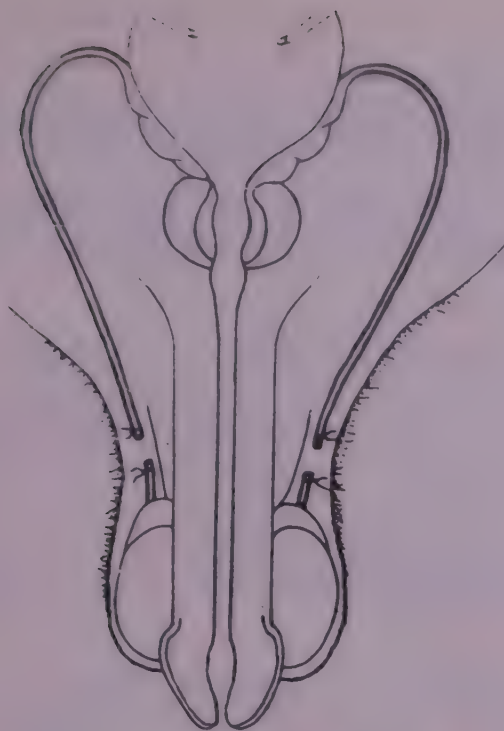
## Vasectomy:

This is an operation done on men and consists in cutting and tying the two tubes (vas deferens) that carry sperm from the testes. When the operation has been done, fertilization of the woman's ova is no longer possible since no spermatozoa can reach the vagina.

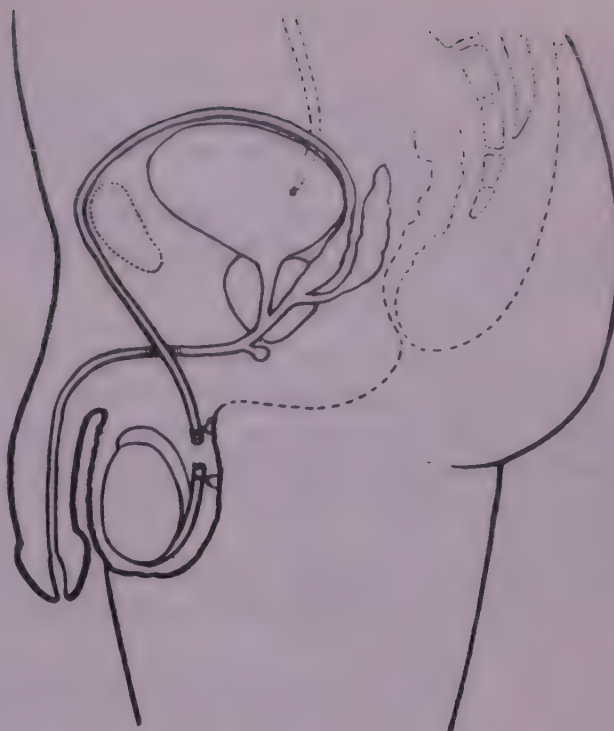
### Advantages:

- i. It does not require hospitalization
- ii. It does not in any way interfere with sexual desire or intercourse.
- iii. It does not reduce the capacity for physical or mental work.
- iv. After the initial twelve ejaculations following the operation, no further action is needed to prevent concepti





*Vasectomy (front view)*



*Vasectomy (side view)*

#### Limitations:

- i. The results of the operation can usually be reversed by recanalization, but this is not always successful. Hence, careful selection of men for this operation is necessary.
- ii. Nirodh will have to be used during the first twelve ejaculations after the operation or until the laboratory test confirms that spermatozoa are no longer present in the semen.

VASECTOMY IS A SIMPLE, SAFE AND PERMANENT METHOD OF FAMILY PLANNING FOR THE MAN.

#### Common fears and doubts about vasectomy:

Although vasectomy has been proven to be a safe and simple procedure, many men have certain fears and doubts about the operation. Their main fears are usually related to the following:

- i. The harmful effects that they think it will have on their sexual function
- ii. The pain and discomfort connected with the procedure.
- iii. The effect it will have on their ability to work.
- iv. The physical risk of the operation.

You must assist the Field Supervisor and CHVs in reducing such fears and doubts particularly among women who fear that the husband will become impotent after the operation.

Points for emphasis regarding vasectomy:

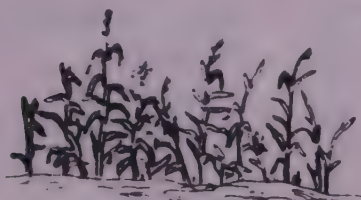
- (1) It is a simple procedure that can be done by the doctor in 10 to 15 minutes. The man can go home within a short while after the operation.
- (2) The procedure consists in cutting and tying the tubes that carry the spermatozoa to the penis so that the sperms cannot be released during intercourse.
- (3) Vasectomy is not the same as castration which is done to animals. The testes are not touched or removed so that a man who has had a vasectomy done will not become obese, and will not have any change in his sexual desire or in his ability to carry out sexual intercourse or his usual type of work.
- (4) It is the method of choice for men who do not want any more children since it is a permanent method of contraception.
- (5) It is always done free of charge by specially trained doctors at the Primary health Centre or in a central place or camp which is temporarily set up. It is done in your institution too. Find out from the doctors.
- (6) Follow-up services are provided for acceptors. The Field Supervisor and CHVs will visit the man in his home after vasectomy and medical care and free medicines from the doctor at the sub centre will be available if needed.
- (7) Incentives for acceptors as well as for motivators are available. These incentives vary from State to State. Find out what incentives and compensation payments are available in your state for persons undergoing vasectomy and what incentives are available for motivators, so that you can give the community this information.



## CHILD SPACING:

A father and his son were planting corn. the son asked his father why the corn wasnot planted closer together in order to obtain more per hectare. the father explained that if there is space between the plants, they grow stronger and healthier and produce more grain. Can you see the relationship between little corn plants and children?

TOO CROWDED



They do not grow well.

WELL SPACED



They grow healthy and strong.

SPACING A PREGNANCY CAN PROTECT THE HEALTH OF THE MOTHER AND HER CHILD BECAUSE:

- i) She is less likely to have serious complications of pregnancy.
- ii) She is less likely to produce a weak, low birth weight baby.
- iii) She will have more time and energy to care for the baby and for other children.
- iv) The time interval between pregnancies will help her body to recover from the burden of child bearing.

### SPACING BIRTHS: REDUCES DEATHS

Bangladesh: World Fertility Survey. Rutstein '82

Spacing between birth	Infant Deaths /1000 births	Toddler Deaths /1000 alive	Child Deaths /1000 alive
	0-1st. birthday	1 st.-2nd. birthday	2nd-4th birthday
 Less than 2 years	185	42	81
 2-4 years	89	28	62
 Over 4 years	58	10	27

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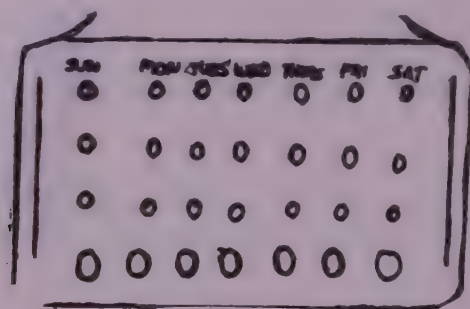
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## TEMPORARY METHODS FOR WOMEN:

### 1. ORAL PILLS

- \* Oral pills usually contain two hormones which are normally produced by the ovary. The ovaries produce the female egg when the amount of hormone in the body is at a certain level. If this amount is increased the ovaries do not produce the egg.



ORAL CONTRACEPTIVE PILLS -  
Contain estrogen and  
progestin (these are  
chemical hormones), which  
prevent the ovaries from  
releasing an egg each  
month.

- \* so when the woman takes one pill (hormones) every day the hormones in the body are increased. And therefore the ovaries do not produce the egg.
- \* The pills must be taken on a prescribed monthly schedule to be effective and are supplied in a package. Each contain 28 pills.

Effectiveness: If regularly taken it is 100% reliable.

#### Advantages:

- \* It is an effective method
- \* There is no interference with the sex act
- \* whenever pregnancy is wanted it can be discontinued.

#### Limitation:-

- \* side effects may occur i.e. nausea, headache, bleeding between menstrual periods or increase in weight.
- \* If requires to be taken daily. If a women forgets to take it on any day she is likely to get pregnant that month.



### Contraindications:

- \* pregnancy
- \* high blood pressure, thrombosis varicose veins (blood clots in legs)
- \* jaundice during the past 6 months.
- \* severe one - sided headache (migraine)
- \* breast feeding
- \* epilepsy or Fits
- \* thyroid disease (swelling in the neck)
- \* diabetes
- \* lump in the breast.
- \* previous stroke or Heart attack

### Selection of clientile:

Oral pills are suitable for:

- \* a newly married couple who wish to delay starting a family.
- \* a mother with one or two living children who wants to space her next pregnancy
- \* a woman who is capable of taking the tablets regularly.

### Administration (Instructions for use)

- \* The first tablet is taken by mouth on the 5th day of the menstrual cycle (counting the first day of bleeding as No.1). Take tablet from the pocket marked as start.
- \* Then take one tablet a day in the order indicated by the arrows on the pack till all tablets are consumed.
- \* The new pack is started the very next day.
- \* Tablets should be taken every day at a fixed time, preferably before going to sleep.
- \* If she forgets one pill she should take it as soon as she remembers. This means if she forgot it in the morning she can take it in the afternoon or the evening. But if she forgot it "yesterday" then she should take 2 to-day i.e. one for yesterday and one for to-day.
- \* If she forgets on 2 days and remembers it on the third day. She should take 2 on the day she remembers and two the next, so that she will finish the packet on the right time.

## Follow-up:

1st visit within 2 weeks after being put on the pills.

- (i) Enquire if woman had any problems
- (ii) Treat minor ailments and reassure
- (iii) Make sure she has no serious complaints (cramp, pain & swelling in the legs, chest pain severe headache)
- (iv) Make sure she is taking the pills as instructed.

## 2nd visit

- one month after she has been put on the pills.
- Enquire if woman had any problems
- Make sure she is taking the pills as instructed.
- give another months supply.

## 3rd and subsequent visits

- continue to revise instructions.
- check for minor ailments; reassure
- may give 3 months supply
- emphasise that she must be examined every six months while on the pill.

A WOMAN WHO IS SATISFIED WITH THE PILL SHOULD BE REQUESTED.

- to motivate others to use the pill
- to participate in family planning promotional activities.

## 1. THE IUCD

### 1.1 What is an IUCD?

It is an object which is placed inside the womb of a woman by a trained person (doctor, nurse, midwife etc.) to prevent an unwanted pregnancy. It comes in many shapes (see below)

### 1.2 What is it made of?

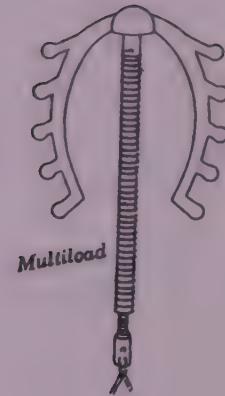
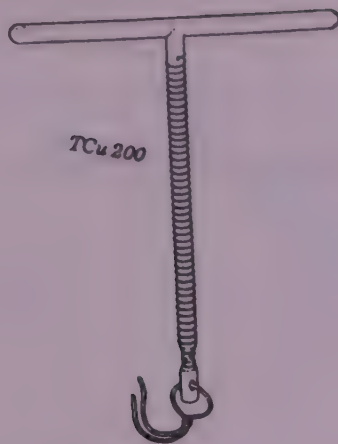
There are many types of IUCDs made with different materials but the ones commonly used in our country are either made of special plastic or plastic with a little bit of copper. They have a thread tied to their end.

### 1.3. The thread and its purpose:

The thread which is tied to the IUCD is not all pushed into the womb. Part of it remains in the vagina. The thread is for 2 purposes. The presence of the thread in the vagina is a sign of the presence of the IUCD in the womb and also when the woman wants to have a baby, the doctor or the midwife can hold the thread with a special instrument and remove the IUCD easily.



## IUCDs in Common use



Those made of special plastic are:

- (a) Copper T - most commonly used now
- (b) Saf - T - Coil

There are many others but you will probably never see them because our clinics do not have them. If you see a new type of IUCD ask the doctor to explain about it to you.

### Mechanism of action

Possibly by altering the lining of the wombs.

Effectiveness: 98% reliable.

### Advantages of IUCD:

- 2.1 Inexpensive
- 2.2 No daily effort required
- 2.3 Does not require frequent visits to the clinic
- 2.4 Can be easily removed when the woman wants to become pregnant
- 2.5 Can stay in the womb for many years without any side effects.

### Limitations:

- i) There may be some bleeding or pain during the first few days after insertion. This is usually temporary.
- ii) The first two or three periods may be longer in duration and the bleeding may be more.














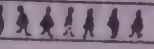
In the following pages there are some questions about the IUCD most commonly asked by the mothers. Not all the mothers will ask you all these questions. Some might ask one or two, some might ask more. This long list is to help you become familiar with different questions and their truthful answers.

REMEMBER, each question is based on certain amount of doubt or fear. Your duty is to help in clarifying mother's doubts and in removing or at least minimising her fears.

You must always be gentle, polite and look unhurried. This encourages the mother to ask questions.

With each question there is a suggested answer/approach. You may use any words as long you convey the correct information.

AVERAGE EFFECTIVENESS OF DIFFERENT FORMS OF BIRTH CONTROL

Of each 20 women using this method . . .	on the average this many are likely to get pregnant in spite of the method . . .	and this many must (or should) stop the method because of problems.
PILL		
CONDOM		
DIAPHRAGM		
FOAM		
I. U. D.		
PULLING OUT		
STERILIZATION		
SPONGE		
RHYTHM		COMBINED 
MUCUS		



## COUNSELLING FOR IUCD

Questions	Your answer / approach
Will it hurt to have the Copper T put in?	No it does not hurt. You will feel a little "pinch" when the doctor holds the neck of your womb. Apart from that you will feel very little pain - just a bit of discomfort for one or two minutes. Very rarely there is a bit of gripe like pain afterwards but it does not last.
Does it hurt afterwards?	Some women feel nothing at all. Some women get a dull back ache before or during the periods or some lower abdominal discomfort but these usually go away within 2-3 months.
Will it hurt my husband?	No. It will not hurt your husband because the Copper T is in the womb. Only the thread is in the vagina. Since the thread is wet all the time it is very soft. Your husband should not feel it at all.
My friend had the Coppr T (or) I heard a woman had the Copper T and she became pregnant.	Yes. It is possible but it is not common. If 100 women have the IUCD in for one year it is possible that only one or two will become pregnant.
What happens to the baby?	(This question has many meanings find out what is on her mind) What do you exactly mean by that ?
I mean when a woman becomes pregnant with the Copper T. Will it hurt the baby like it might go through his eyes?	No, it does not hurt the baby in any way because as you know the baby is in a bag full of water and the Copper T is outside the bag. The Copper T cannot touch the baby. It comes out with the "afterbirth".
Will it fall out if I carry something heavy?	A Copper T can sometimes fall out but not by carrying heavy things. The falling out has no connection with your doing heavy work.
I want more children. I hope this Copper T will not make me sterile.	No. The Copper T will not make you sterile. When you feel you want to become pregnant, the doctor will take it out for you.

Will it hurt when the doctor takes it out?

I hear from somewhere that the Copper T causes cancer.

People talk or I don't remember  
Some body I met in a friends house etc.

I heard that one women had a lot of bleeding and the doctor took her Copper T out.

Can it go up into my stomach

No. Not at all. You will not feel any thing.

Who told you that?

You are a sensible woman let me ask you a question ?

Would a doctor put in the Copper T knowing that it will cause cancer : Or would the Ministry of Health let the Copper Ts come into the country if it caused cancer ?

or

I would suggest that if you have any questions about health please ask a doctor or a nurse.

I assure you the Copper T does not cause cancer. Millions of women have the Copper T in and are quite happy with it.

Yes. It is possible. Usually a woman's body takes 2 to 3 months to get used to the Copper T. Some bodies do not get used to it and the Copper T has to be taken out. (you may add) You see the thing is that hundreds of women in our coutry have Copper Ts. They are perfectly satisfied. These women never talk about it that is why you seldom hear about many many good things of the Copper T. If one women has a problem she talks about it to ten or twenty other women. Then they talk to a few more and wthin 2-3 days the whole village knows about this one unusual case but no one knows about the hundreds of women who have no problem with the IUCD. That is why you only hear about the complicated cases.

Let me show you what your womb looks like. (Show model or picture) You see your womb is not connected to your stomach. These are two separate bags and have no connecting pipe. The IUCD cannot go to your stomach.



How long can I keep it in?

The Copper T that you are getting can stay in as long as you like.  
(In case of copper T)

The Copper T that you are getting has to be changed after 3 years.

How often do I have come for a check up?

When you get the Copper T your first check up is after one month. The next check-up is after 6 months and then once a year. But if you have any problems you are welcome anytime.

Note: After a mother finishes asking questions.

You may add.  
Do please ask if you have any more questions. If I do not know the answer I will find out from the doctor

---

#### Instructions following insertion:

After a woman has had an IUCD inserted, explain to her that:

- i) she may have slight pain in the abdomen for a few days;
- ii) there may be slight bleeding for a few days;
- iii) the next menstrual period may be heavier than usual;
- iv) the Copper T may be expelled spontaneously and if this occurs she should inform you;
- v) if she has any problems such as severe pain, heavy bleeding or vaginal discharge, she should return to the clinic for treatment;
- vi) she can have sexual intercourse any time after insertion of the Copper T without using any other contraceptive;
- vii) she can carry out her usual work after insertion of the Copper T.

FIND OUT WHAT INCENTIVES ARE AVAILABLE IN YOUR STATE FOR IUCD ACCEPTORS AND INFORM THE WOMAN ABOUT THESE BENEFITS.

#### Follow-up of women inserted with an IUCD

It is important that you should follow up all those women in whom an IUCD has been inserted. Some of them have mild symptoms which merely need simple treatment and assurance. Others have more serious side-effects for which they must be referred to a doctor. A satisfied IUCD user can be very helpful in motivating her relatives and neighbours to accept the method, whereas a woman who is dissatisfied with the method can spread alarm among all the women in her village so that none of them will be prepared to accept the IUCD.

The schedule of visits at home or at the clinic should be as follows:

1st visit (Home visit) - Within three days after the IUCD is inserted:

- i) Ask her how she is feeling.
- ii) Enquire if she has any pain or bleeding.
- iii) Provide treatment if the symptoms are mild.
- iv) Reassure her.
- v) Refer her to the sub centre if she has:

- (a) Severe pain.
- (b) Heavy bleeding.

2nd visit (Home visit) - After the menstrual period:

- i) Identify & treat minor symptoms give iron and folate tablets one twice daily
- ii) Reassure her
- iii) Refer her to the subcentre if she has:
  - (a) Fever 38 degree Centigrade or above
  - (b) Foul smelling vaginal discharge
  - (c) Severe bleeding
  - (d) Severe abdominal pain

3rd visit (clinic visit) and subsequent visits - At least once in three months:

- i) Enquire about her last menstrual period:
  - (a) whether it occurred at the expected time;
  - (b) whether it was more prolonged than usual;
  - (c) whether it was accompanied by pain.
- ii) Ask her whether she has noticed if the Copper T has been expelled.
- iii) Identify and treat minor ailments. Give iron and folate tablets one twice daily
- iv) Encourage her to continue using the IUCD.
- v) Ask her to motivate others to have an IUCD inserted.
- vi) If she has any serious complaints such as prolonged or heavy bleeding, severe pain, or continuous vaginal discharge, in spite of treatment, refer her to the PHC.

The likely side-effects which you may meet with are as follows:

- (1) Bleeding
- (2) Pain in the abdomen or low backache
- (3) Vaginal discharge
- (4) Fever

PROLONGED OR SEVERE BLEEDING, SEVERE PAIN AND VAGINAL DISCHARGE WITH FEVER ARE SERIOUS SYMPTOMS. THESE CASES MUST BE REFERRED PROMPTLY TO THE DOCTOR.



## Side Effects and Complications of IUCD

Side effect	Your action	Advice to the mother
Upto 3 months after insertion	Check date of insertion and ask. 1. How many times did you change the pad(cloth) in one day before you had the IUCD and how many times after the IUCD.	Do not worry. You will have 2 or three heavy longer periods, then you body will get used to the Copper T and your period will become normal.
Heavy periods and/or longer periods	2. How many days did your periods last before IUCD and how many days do they last now.  If she is changing 2-3 more pads than before and/or her periods lasts 1-2 days more, no treatment is required. Reassure her.	Remember I told you this the day you got your Copper T But if the bleeding increases please come and see the doctor.
Spotting irregular bleeding	check date of insertion. if less than 3 months. no treatment is needed.  Reassure her.	I know it is a nuisance but it is harmless. Some woman get it.  It will correct itself within 2-3 months. Do not worry.
Lower abdominal pain or discomfort	Check date of insertion. Ask the mother if it is bearable or she wants some medicines. If she wants some medicine give her Aspro or something similar available in the subcentre Reassure her. If she seems too worried, let her see the doctor.	Do not worry. Some mothers get such pains but it goes away after 2-3 months. If it becomes too much take something like what you would take when you have a headache Use a hot water bottle.  If it bothers you a lot come back on the clinic day The doctor will be here.

Vaginal discharge

Check date of insertion.  
If less than two months  
then; No treatment required.  
Reassure her.

This happens sometimes. It  
Usually clears up after  
1 -2 months.  
Do not worry.

---

Falling out of IUCD

Most mothers brings the IUCD  
with them if it falls out.  
If the mother has the IUCD  
skip the first question.

ASK

"You better see the Doctor"

1. How do you know it fell out?
2. When did it happen?
3. Have you been with your husband since it fell out?

"Please come back on the  
clinic day  
the doctor will be here".

4. If it fell out 1-2 days ago AND the mother has not slept with her husband OR if the mother is having a periods then the doctor might like to put another one immediately.

2-3 days interval  
between the falling  
out of the IUCD and  
her next visit to  
the clinic.

Advise the mother to avoid  
intercourse.

You know with the IUCD  
out you might become  
pregnant.

So please do not sleep with  
your husband until you have  
until the doctor.

More than 3 days  
interval between  
the falling of  
the IUCD and her  
next appointment.

If you are not allowed to  
do so then give condoms

Nirodh is for your  
husband and your husband  
should use this for prote-  
ction, until you get IUCD.  
Otherwise you may become  
pregnant.

More than 3 days  
interval between  
the falling out of  
the IUCD and next  
insertion. But an  
alternative cannot  
be provided by you.

Advise purchase of condoms.  
Tell her you cannot give  
her anything and explain  
why?  
eg. Too late for the pill;  
OR Nothing else is avail-  
lable;  
OR Doctor is not her today.

"Please request your  
husband to buy some  
rubbers and use them until  
you get your next visit.  
I am very sorry I cannot  
give you something because  
(explain reason)



Missed periods  
(possibility of  
pregnancy)

Make sure she is not  
mistaken about her dates.  
If you tell her.

Don't worry. You still have  
... Days to go.

To (1)

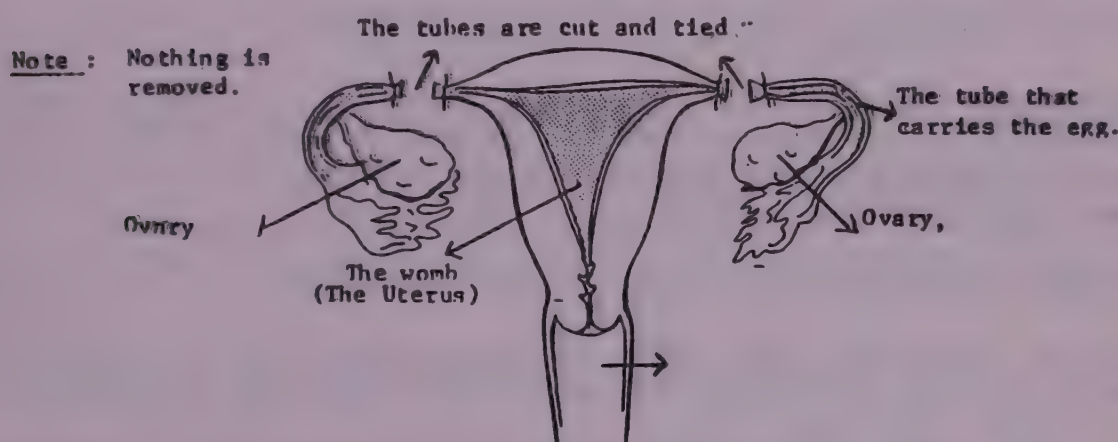
If no mistake refer her to  
the doctor.

Yes it seems your periods  
are late.

You better see the doctor.

### Tubectomy (tubal ligation)

In India the term 'tubectomy' refers to the operation in which the fallopian tubes are ligated with or without cutting. This prevents the sperms from meeting the ovum so that conception cannot occur.



### Advantages:

(i) After the operation has been performed, no further action is necessary by either the man or the woman for preventing conception.

(ii) The operation can be done immediately after delivery in a hospital, or it can be carried out at the time of some other lower abdominal or vaginal operation, or at any other time convenient for the woman.

(iii) The operation is done free of charge in a government hospital or Primary Health Centre.

### Limitations:

i) The woman has to stay in hospital for about a week.

ii) The results of the operation can be reversed by recanalization, but this is not always successful.

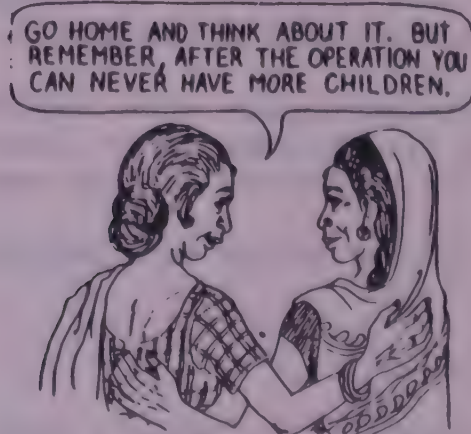
Your responsibilities will be as follows:

- (1) To select and motivate women to undergo tubal ligation.
- (2) To answer any questions and clear any doubts and misconceptions the community may have regarding tubal ligation.

Selection of women for tubal ligation:

The criteria for selecting women for tubal ligation are as follows:

- (1) The husband should be living.
- (2) The woman should not be below 20 years or above 44 years and she should still be having menstrual periods.
- (3) The man should not be below 25 years nor should he be over 50 years old.
- (4) The couple should have two or more living children.
- (5) In cases where there are only two living children, the age of the youngest child should be two years or more. It must be ensured that the children are not suffering from any serious disease and that they have received all the necessary immunizations.
- (6) The couple should preferably have at least one son.
- (7) Unless the couple have been using contraceptives, the wife should have had her last delivery or abortion not more than five years previously.
- (8) The couple should not want any more children and should understand the full implications of sterilization.
- (9) Neither spouse should have undergone sterilization previously.





If you have any doubts as to the suitability of a woman for sterilization you can discuss this problem with your supervisor. The doctors at the PHC or those who conduct camps will do the final screening of women who will undergo tubal operation.

Common questions, fears and doubts about tubal ligation.

(1) Will I be conscious during the operation?

The type of anaesthesia given will vary from hospital to hospital. In some cases the woman is given a spinal injection or local anaesthesia so that she does not feel the pain but remains conscious during the operation. Other doctors perform the operation under general anaesthesia (either inhalation or injection so that the woman is not conscious during the operation.

(2) How long will I have to stay in the hospital?

The woman will have to stay in hospital for about seven days, i.e., until the wound has healed and the stitches have been removed.

(3) Will I have any pain or discomfort during or after the operation?

There will be no pain or discomfort during the operation. For the first few days after the operation there will be some pain at the site of operation and some discomfort as with any other operation, but this will soon pass.

(4) How soon after the operation can I take a bath?

Once the stitches are removed and the woman comes home after the operation, she can take a bath.

(5) For how long after the operation must I take rest?

As in the case of other abdominal operations, the woman can walk about with two or three days after the operation and after about 10 days she can do light work in the house. However, she should not carry heavy loads or do heavy manual work for at least three weeks following the operation.

(6) Incentives for acceptors as well as for motivators are available. These incentives vary from State to state. Find out what incentives and compensation payments are available in your state for persons undergoing vasectomy and what incentives are available for motivators, so that you can give the community this information.

#### HOW TO TEACH THESE LESSONS TO CHV'S

9800'

Is

Start by asking the CHVs how many pregnancies they have had and how many living children they have.

ASK: Do people in your village like large or small families?

Get the CHVs to talk about local attitudes to family size, sons rather than daughters, spacing of pregnancies, how having children affects the status of women, etc.

ASK: What are the disadvantages of having too many children?

Answer:

1. It is more expensive to feed and clothe a large family.
2. The mother can't look after all the children properly so the children get neglected.
3. The mother becomes weak through frequent pregnancies so there is more risk of her having weak babies.
4. Weak and neglected children get sick and die more often than well-cared for children.
5. Already many people in India cannot get work. Large families mean more people without jobs and less food for every one.

DISCUSS: How can we change people's attitudes so that they will be happy to have just one or two children?

Give the CHVs time to think and talk through conflicts between their present attitudes and the new attitudes you would like them to have. Do not rush them or force new ideas on them. Allow them time—even if it takes weeks or months — to accept for themselves that small families are best.

EXPLAIN: There are various ways to avoid having too many children. Parents can decide to space their families so that there is a gap of 3 or more years between births. Ways of spacing births are:

1. Condom
2. Copper T
3. The Pill
4. Sleeping together only during the safe period of the month.



**SHOW:**

Samples of condom, Copper T, and the pill.

**Explain:** the advantages and disadvantages of each:

**Condom:** Easy to use, but man may not like wearing it, and it sometimes bursts so is not completely safe.

**Copper T:** needs a doctor or nurse to put it in, but once in it gives little trouble. Sometimes it causes a bit of pain at first and heavier periods for a few months.

**The Pill:** very easy to take but also easy to forget.

Causes blood-clotting and blood pressure problems in some women so need for regular check-ups.

Sleeping together only during safe period of each month is not a very good method and often fails, but it costs nothing and is better than no method at all.

**ASK:**

Is anyone in your village using any of these methods of family planning? Which method is most popular? Why?

(Find out from the CHVs what village people think of the various methods of family planning and why they prefer one to another. This will help you to know what to emphasise in your teaching and how to correct wrong ideas they may have.)

**EXPLAIN:**

Family planning do not make a person weak or in any way spoil their ability to have sex. In fact, they will enjoy sex more because they do not have the fear of unwanted pregnancies.

It is important to realise, however, that after vasectomy a man may shed sperm for another 3 months so he should use a condom during this time. After 3 months it is safe for him to stop using a condom.

After tubectomy it is immediately safe for the couple to have sex.

## IMMUNIZATION

Some important vaccine preventable diseases in children are:

- Tuberculosis
- Diphtheria
- Whooping cough
- Tetanus
- Measles
- Polio

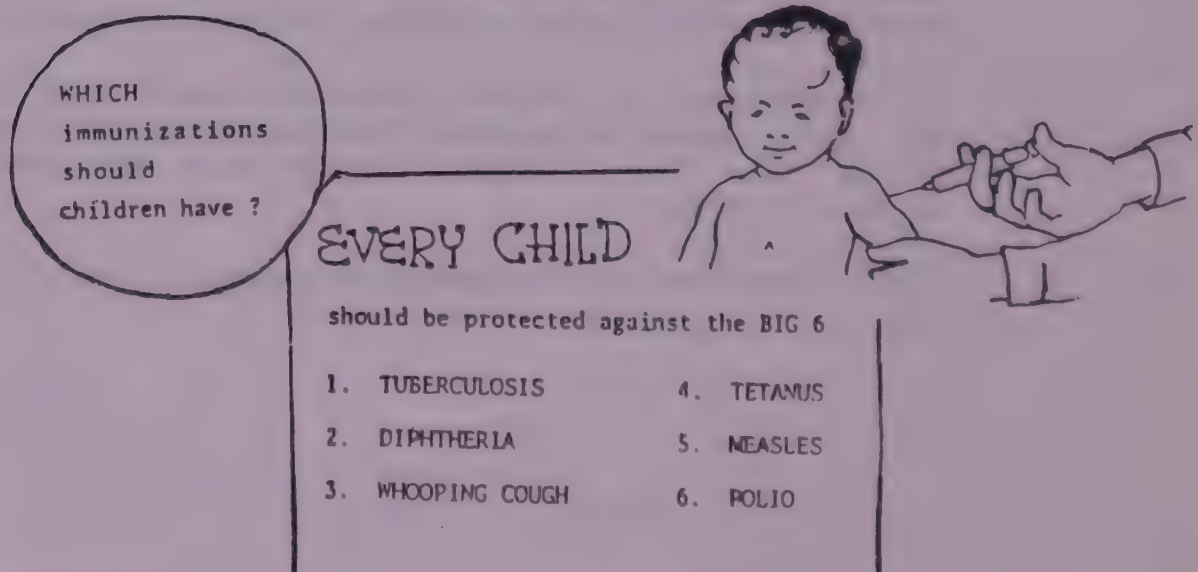
### 1. Importance of Immunizations:-

What is immunity?

It is the strength of the body of fight against infections.

#### 1.1 PREVENTION OF DEATH AND DISABILITY :

An analysis of data from 1981 sample survey shows that nearly 230-280 thousand infants die within the first month of life from neonatal tetanus a disease totally preventable by immunizing pregnant mothers against tetanus. The annual mortality of children in India from polio is about 2000. Polio is the major cause of lameness among children - again both death and disability can be prevented by effective Polio Immunization Measles is also a major killer 200,000 children die each year from this disease. Measles vaccine can prevent these deaths.



#### 1.2 OF ALL HEALTH SERVICES IMMUNIZATION IS THE MOST COST EFFECTIVE:

The cost of immunization one infant (0-12 months) is estimated to be under Rs. 60/- year; (compare this with the cost of treating a single case of any one of these six preventable diseases e.g. the cost of treating a single case of tetanus is several thousand rupees.



## 2. Government Policy on Immunization:

\* EPI - Expanded programme of Immunization was started in India in 1978 with the objective of reducing the morbidity and mortality due to diphtheria, pertussis, tetanus, poliomyelitis and Typhoid.

\* Universal Immunization by 1990

Vaccine services are proposed to be made available to all eligible children and pregnant women by 1990. It is proposed to include measles in the EPI during the 7th plan (1985-1990).

\* Present status: % of one year old children fully immunised

(1982-1983)

TB	DPT	POLIO	MEASLES
18	39	18	-

Source : State of the worlds children 1985-UNICEF.

The National Health Policy has set the following specific targets for the programme of Universal Immunization by 1990.

Vaccine	Target	Immunization status % population 1990
DPT	Infants	85
Polio	"	85
BCG	"	80
TT	Pregnant women	100
TT	School children 10-16 yrs	100
DT (Diphtheria tetanus)	New School entrants 5-6 yrs	85
Typhoid	"	85

Source: Towards Universal Immunization 1990 - Ministry of Health and Family Welfare, Government of India New Delhi - 1985.

### 3. Dosage schedule

#### 3.1 Recommended Government schedule of immunization for children

Age	Immunization
At birth or as soon as possible after birth	BCG vaccination
4 to 9 months	DPT (triple vaccine): 3 doses at intervals of 8 to 12 weeks
	Poliomyelitis (trivalent oral vaccine): 3 doses at intervals of 4 to 6 weeks
11 months	Measles vaccination
1 1/2 to 2 years	DPT booster: 1 dose

#### 3.2 Vaccine recommended ages, route of administration and intervals between doses.

Disease	Vaccine	Route	Minimum age at 1st dose	Maximum age at 1st dose	No. of doses	Interval between doses
Tuberculosis	BCG	ID	At birth	5 yrs	1	-
Diphtheria Pertussis Tetanus	DPT	IM	6 weeks	5 yrs	3	not < 4 weeks not > 6 months
Polio	OPV	Oral	6 weeks	5 yrs	3-5	" "
Measles	Measles vaccine	SC	1 yr	5 yrs	1	-

Ideally by 1st year of age a child should have:

- \* BCG
- \* 3 DOSES OF DPT & OPV
- \* Measles Vaccine

#### 3.3 Pulse Immunization:-

- \* This is a strategy for community based mass immunization which involves.



\* Adequate information to the community through your CHVs and "town-criers", youth groups, womens groups, local leaders etc. regarding

- dates and time of immunization
- site of immunization
- who should come for immunization (i.e. children from 0-5 years)

\* Co-ordination with health team responsible for immunization of children Government or voluntary agency who will make a visit once a month if possible or once in two months to the same community.

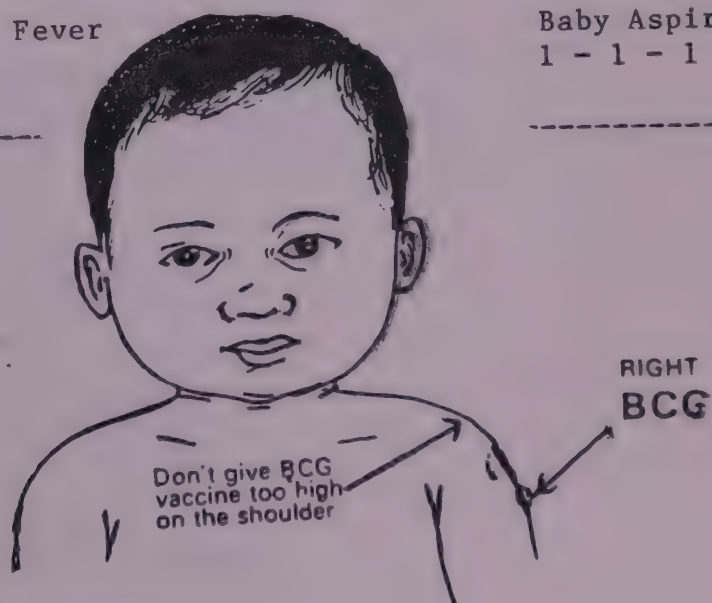
\* A system of record keeping (preferably at field level).

\* Advantages are - problems of vaccine storage and transport are minimised; community involvement and participation generated can be utilised for further health and development activities.

Experience has shown coverage is better with this strategy than with the traditional method of immunization through MCH clinics.

#### 4. Precautions and Possible Reactions:

Vaccine	Precaution	Reaction	What to do
1. BCG	Strictly Intradermal	Infection at the site of Injection	Refer to Doctor
2. Polio	Avoid breast feeding 1 hr before and after dose	Rarely diarrhoea	Reassure
3. DPT	Nil	Swelling at site of injection, fever for 24 - 36 hrs	Hot fomentation Baby Aspirin 1 - 1 - 1
4. Measles	Subcutaneous	Fever	Baby Aspirin 1 - 1 - 1



## 5. Important of maintaining a Record of Immunization:

### 5.1 Why record keeping is important.

\* TO AVOID DUPLICATION

\* TO ENSURE PROPER COVERAGE

- many voluntary organisations, ladies' clubs as well as Govt. Field Staff are becoming involved in immunizing children.
- because of lack of cooperation and co-ordination between the various agencies children are being immunized haphazardly resulting in
- WASTE OF VACCINES
- INADEQUATE PROTECTION

### 5.2 How to keep a record

- the easiest way is to maintain individual cards for children (Health card) and enter the date on which each dose is given.
- maintain a register with names of children immunized and dates given

### 5.3 Where should the record be kept.

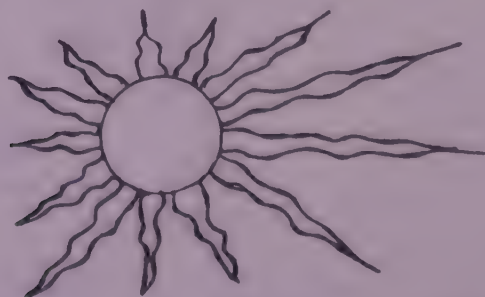
\* There is no " correct answer"

\* Ideally mothers should be entrusted to maintain their children's health card

### 5.4 How to conduct an immunization programme in the field level.

Refer Annexure

**KEEP SUNLIGHT AWAY  
FROM VACCINES**



**sunlight harms vaccines**



## 6. How to impart this knowledge to the community

### 6.1 Begin with the existing knowledge in the community regarding immunizations

- Do they know diseases like diphtheria, tetanus, whooping cough, polio etc., can be prevented. Use local terms.
- Have any children in the community been immunized?
- Explore reasons why children have not been immunized- fears about reactions, etc., myths about the diseases.
- Educate the community based on their existing knowledge.

(Given information parents can be actively involved in participate in organising and implementing an immunization programme in their own community)

Parents need to have the following information in order to be able to utilise immunization services.

- \* Which disease immunizations protect against and that all diseases are not prevented by immunizations.
- \* Which age groups are to be immunized and why other age groups are excluded.
- \* The need for repeated doses
- \* That immunizations are safe and that reactions like fever are a sign that the body is working to build up their child's protection.
- \* That vaccines are of no use once the child has contracted the disease.
- \* Vaccine reactions and how to handle this?

### 6.2 Guidelines for role play:

- \* Divide participants into two groups. One group will play the role of community health volunteers trying to educate a community about immunizations. The second group observes the role play and makes comments based on an observer's checklist.

### 6.3 Observer's checklist (Trainers of CHVs)

- approach to the community
  - \* respect for existing knowledge
  - \* method of giving information
  - \* skill in dealing with existing fears/myths

- extent of community involvement

- \* use of existing community groups
- \* use of existing formal and non-formal leaders

7. Guidelines for training CHVs

7.1 CHVs needs to know (Knowledge)

- \* some diseases are easily prevented but difficult and very expensive to cure, e.g., tetanus, whooping cough, polio, TB.
- \* we can take "special medicines" - VACCINES to prevent some diseases.

BCG vaccine protects us from TB

DPT vaccine protects us from diphtheria, pertussis and tetanus

Polio vaccine protects us from polio

Measles vaccine prevent measles.

- \* all children should be given these vaccines - starting if possible from the age of 6 weeks.

BCG vaccine - one injection given in the arm intradermally

DPT vaccine - 3 injections are given into the thigh or buttock intramuscularly - 1 injection per month

Polio drops - are swallowed 1 dose a month for 3 months

Measles vaccine - 1 injection in the thigh subcutaneously

- \* Older children and babies who have not had these vaccines should start having them as soon as possible.
- \* How to deal with vaccine reactions

7.2 CHV needs to do (skills)

- \* Explain to mothers the importance and value of immunizations
- \* Inform mothers about specific dates and locations where immunizations will be given
- \* Remind mothers when next dose is due.

7.3 Teaching Methods/Visual Aids, Materials

\* Group discussions

- Ask about any one who has TB in the community
- Ask about the cost of treatment to this family
- Ask if children in this family have been given BCG.



- Explain that BCG protects against TB. Very important that children get BCG especially below 5 yrs in the family of the TB patient.
- How to get children immunized with BCG - through Govt. multipurpose workers/health visitor.
- do the same with polio, tetanus, whooping cough.
- teach about vaccine reactions and how to deal with them.

EMPHASISE THAT ALL CHILDREN BELOW 5 YEARS NEED BCG, DPT, POLIO AND MEASLES VACCINATION.

\* Visual Aids/Materials

- child with a BCG scar if available
- child with Polio deformity if available
- charts/posters

- \* arrange a visit to Govt. health centre where immunizations are given if possible

#### 7.4 Duration

Initial - 7 hrs

- try to fit in a visit to Govt. health centre.

Continuing education at monthly meeting discuss problems if any with immunizations given at village level.

#### 7.5 Resource Persons:

- PMS or field supervisors
- Govt. health personnel
- Staff from the hospital

#### 7.6 Assessment:

- have CHV's set their own targets for immunization coverage
- review progress of all CHV periodically at a group meeting and analyse differences in individual progress

#### 8. Summary:

- \* The Govt has made a committment to expanding its immunization coverage and has set very specific targets to be achieved by 1990.
- \* Voluntary organisations can avail themselves of Govt. support for immunization programmes provided they comply with Govt. reporting requirements.
- \* By one year of age an infant should be protected against tuberculosis, diptheria, Pertusis, tetanus, Polio and preferably measles also.
- \* The major problem area in immunization programmes is maintaining the potency of the vaccines.

## DIARRHOEA AND ORAL REHYDRATION THERAPY (ORT)

### 1. Importance of ORT

#### 1.1 Diarrhoeal disease

What is diarrhoea?

- frequent passage of stools of abnormal consistency, colour, smell
- stools may be watery, (bloody mucousy) (blood & mucous in stools is often called dysentery)



#### \* Why diarrhoea?

Diarrhoea results when the body is trying to get rid of germs which have entered the gut, i.e., THE BODY IS FIGHTING INFECTION by increasing the movement of the gut so that germs that have entered the body are eliminated from the body.

#### \* How do germs causing diarrhoea enter the body ?

- contaminated food & water

FACES  
FINGERS  
FLIES

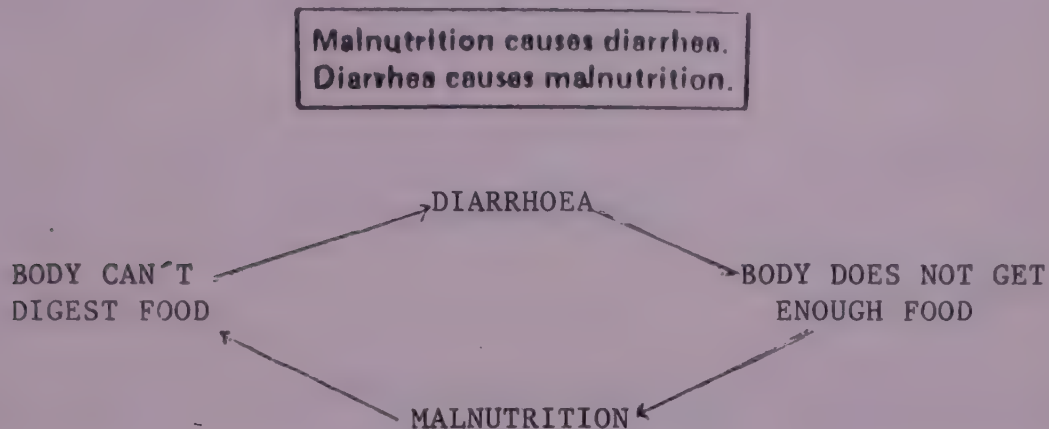
#### \* Therefore diarrhoea can be prevented by

- improvement of water supply, excreta disposal and hygiene
- improving the general health of the child by improved nutrition.



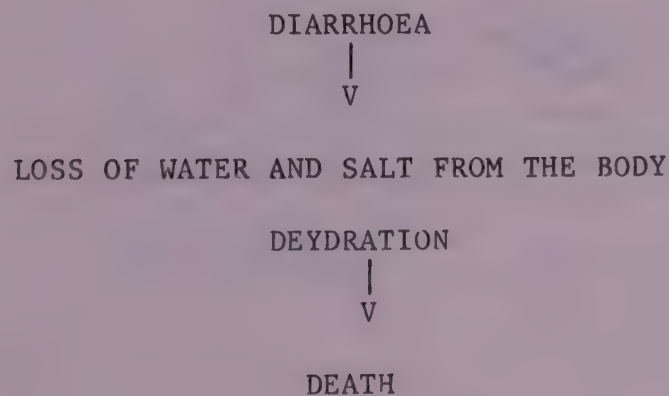
## IMPACT

- \* Diarrhoeal disease is the greatest single killer of children in the developing world and often the chief cause of malnutrition.
- \* Relationship of diarrhoea and malnutrition. The vicious circle of malnutrition & diarrhoea.



### 1.2 Death from diarrhoeal disease

- \* How common is diarrhoea? It is estimated that in poorer communities, a child may contract a diarrhoeal infection 6 or more times a year - with each episode lasting for several days.
- \* Cause of death in diarrhoeal disease



LOSS OF TOO MUCH  
LIQUID IS DANGEROUS

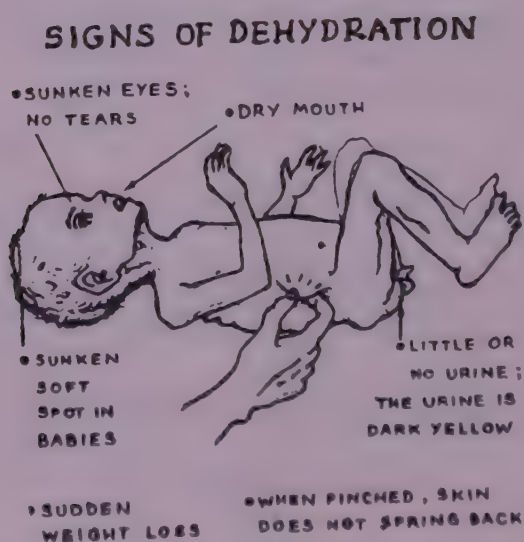
In 1980 in developing countries an estimated 5 million children under 5 yrs of age i.e. about 10 every minute died as a consequence of diarrhoeal disease.

#### MOST DIARRHOEAL DEATHS STEM FROM DEHYDRATION

- 10% of all diarrhoeal disease in children will have significant dehydration.
- 42.2% of deaths in children below 5 years of age are due to gastroenteritis (Health Statistics of India - 1985)

#### 1.3 Signs of Dehydration:

- \* THIRST is the first sign of dehydration
- \* DECREASED ACTIVITY
- \* DECREASED URINE
- \* DRY LIPS AND MOUTH
- \* DULL AND SUNKEN EYES
- \* SUNKEN FONTANELLE IN CHILDREN BELOW ONE YEAR
- \* LOSS OF SKIN ELASTICITY



#### 1.4 Role of ORT in prevention of dehydration and deaths from diarrhoea.

- \* about 92-95% of all patients with acute watery diarrhoea, including infants can be treated with oral rehydration solution (ORS) alone, as seen in the following table.



\* Rehydration Therapy - University Hospital Haiti

Mortality from diarrhoea

1969 - 79 : 9434 cases of diarrhoea - 35% deaths

ORAL REHYDRATION INTRODUCED

1980 - 81 : 3312 cases - 14 % deaths

1981 - 82 : 1.9% deaths

- \* It has been found that the average length of diarrhoea illness was reduced from 5 days to 2 1/2 days in houses where ORS was used. The early use of ORS in the home will normally mean dehydration will not set in and a clinic visit will not be necessary

1.5 Diarrhoea & Medicines

- \* a few children who have desentry (blood & mucous) and cholera infections may receive antibiotics and this may shorten the illness.
- \* substances such as "lomotil" should not be used as they paralyze the gut AND PREVENT THE BODY RIDDING ITSELF OF THE TOXINS AND BACTERIA WHICH ARE CAUSING THE DIARRHOEA.

MEDICINES ?



2. Preparation and use of ORS ( oral rehydration solution)

2.1. Oral rehydration solution

Oral rehydration solution is formulated to replace the nutrients lost during diarrhoea

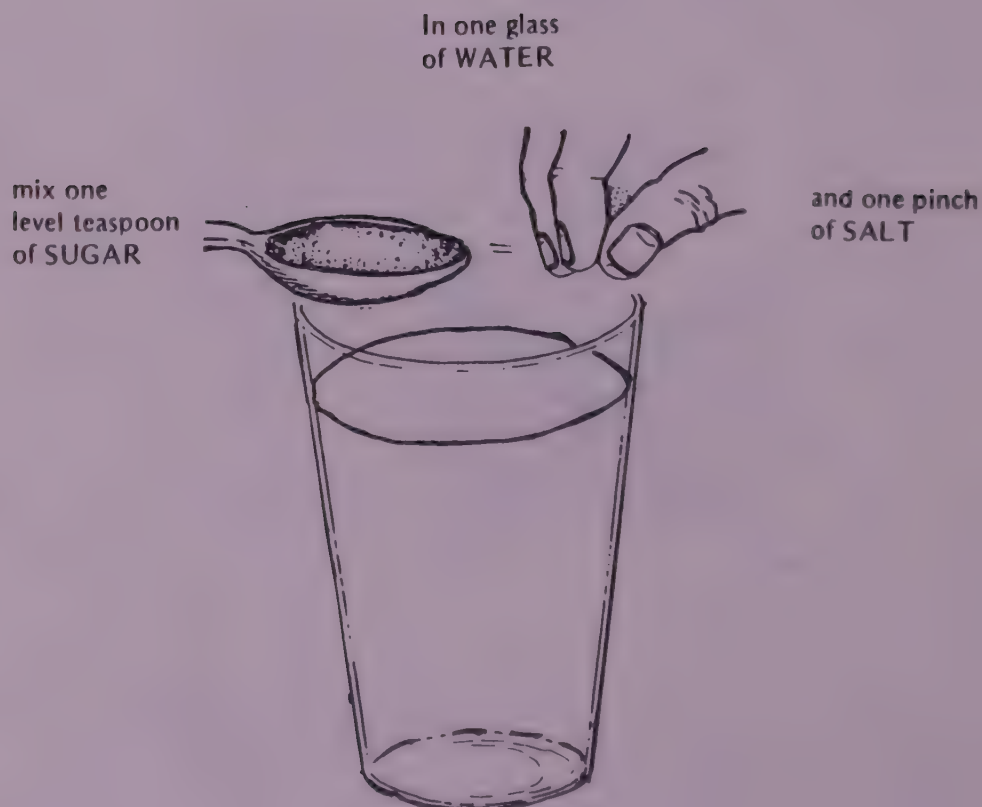
The standard WHO/UNICEF recommended formula for ORS consists of

Sodium chloride- 3.5 grams  
Sodium bicarbonate - 2.5 grams  
Potassium chloride - 1.5 grams  
Glucose - 20 grams

To be mixed with 1 liter of water (preferably boiled & cooled, if not clean water)

## 2.2 Home based ORS

Boiled, cooled water - 1 glass  
Sugar - 1 teaspoon  
Salt - 1 pinch  
Cooking Soda - 1 pinch  
Juice of 1/4 to 1/2 - Lemon





\* If boiled water is not immediately available the best available water may be used.

- i) Take a pinch of salt.
- ii) Take a handful of sugar.
- iii) Squeeze juice of half a sour lime.

Add some of the boiled water to completely dissolve the salt and sugar.

Pour the solution into the litre bottle and add more boiled water to fill the bottle up to the neck.

Shake the mixture.

Cool the mixture until it can be administered without the risk of burning the mouth.

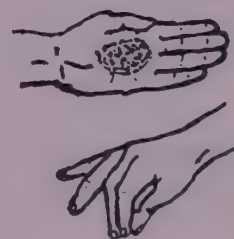
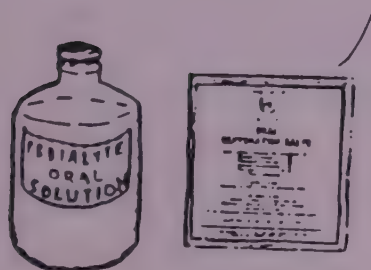
Keep the top of the bottled covered with a clean cork, cap or cloth so that dirt, flies and other insects do not fall into it making it unsafe for use.

\* ORS Once prepared needs to be protected from subsequent contamination.

### 2.3 Cost comparison

Commerical prepared  
ELECTRAL Rs 6.75/Litre

Home made solution  
Less than Rs 1  
(including cost of fire-  
wood for boiling water)



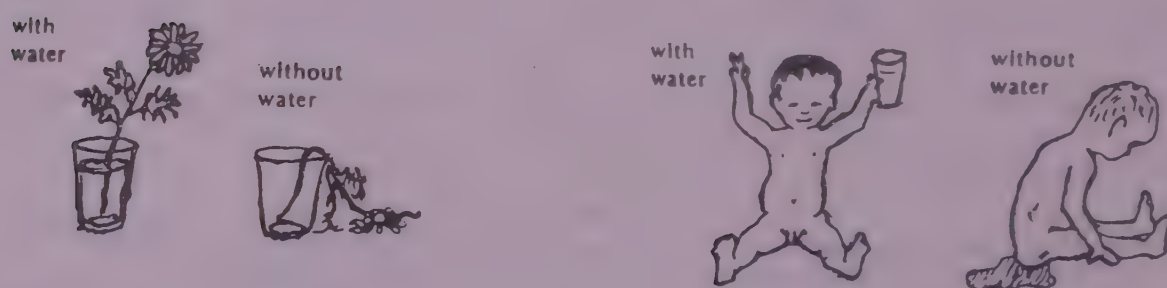
### 2.4 How to use ORS

- \* In all cases of diarrhoea begin ORS at once
- \* average of one glass per stool
- \* important to stress that the solution is not a medicine to stop diarrhoea.
- \* diarrhoea may continue but water & salt which are lost are being replaced and dehydration is prevented.
- \* if vomiting is present along with diarrhoea try giving only small quantities of the solution at a time.

### 3. PRINCIPLES OF ORT

#### 3.1 Importance of replacing water & salts

- \* 80% of our body weight is made up of water. The stools of a child with diarrhoea contain a lot of water - thus the bodywater is lost
- \* a child with diarrhoea also loses mineral salts necessary for normal functioning of the body, he loses:
  - Sodium Chloride ( ordinary salt)
  - Potassium
  - Bicarbonate
- \* a child who dies from diarrhoea is not killed by the infection.



compare this to a child with diarrhoea.

DEATH IS DUE TO LOSS OF WATER & SALTS i.e. DEHYDRATION.

- \* DEATH CAN BE PREVENTED BY REPLACING THE WATER AND SALT WHICH ARE LOST. THIS IS CALLED REHYDRATION.
- \* The cheapest and easiest way to do this is to give him water, salt and sugar - ORS to drink.

If the soft spot is

SUNKEN,

the

baby

may

be

DEHYDRATED

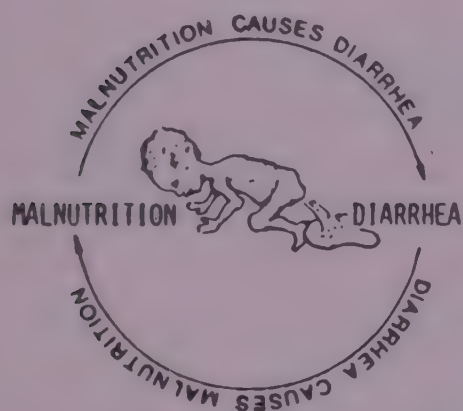


### 3.2 Importance of continued feeding during diarrhoea:

- \* The body needs strength to fight the diarrhoeal infection.
- \* In many societies the parent's remedial response to diarrhoea is to withhold food and water, including breast milk in the mistaken belief that this will stop the diarrhoea and ease the strain on the intestine.
- \* The proper management of diarrhoea in the home includes appropriate feeding along with ORS during and after the diarrhoeal episode.
- \* "Appropriate feeding" means in general, foods that are easily digestible.
  - rice congee
  - curds, rice
  - bananas, apples, carrots

### 3.3 Importance of increasing feeding after diarrhoea stops.

- \* MOST CHILDREN WITH CHRONIC DIARRHOEA ARE OFTEN MALNOURISHED



THE 'VICIOUS CIRCLE' OF  
MALNUTRITION AND DIARRHOEA  
TAKES MANY CHILDREN'S LIVES.

- \* Because of loss of body weight during diarrhoea, most children will have increased appetite for a short period after diarrhoea stops.
- \* It is important to give extra-food at this time so that the body weight lost is regained. This will help to prevent malnutrition and thus avoid the problem of chronic diarrhoea.

### 3.4 Points of Referral:

- \* A child needs to be referred to a clinic if -
  - child keeps on vomiting
  - child develops signs of dehydration in spite of the use of ORS
  - child has high fever
  - diarrhoea persists for more than 3 days.



#### 4. How to impart this knowledge to others?

##### 4.1 CHV needs to know (knowledge)

\* diarrhoea is caused by GERMS GETTING INTO THE STOMACH

- drinking unclean water
- eating unclean food
- letting flies sit on food
- eating with unwashed hands
- prevention of diarrhoea

\* diarrhoea causes loss of water and salts from the body. It is this loss which is dangerous and kills people - especially children.

\* the symptoms of water loss  
(signs of dehydration)

Lift the skin of the  
belly between two  
fingers, like this.



Then let go. If the  
skin does not spring  
right back to  
normal, the child  
is dehydrated.



\* the treatment of diarrhoea

- preparation of ORS
- continued feeding during diarrhoea
- increased food after diarrhoea stops
- referral points

##### 4.2 The CHV needs to do (skills)

- \* educate about cause and prevention of diarrhoea.
- \* demonstrate preparation and feeding of ORS
- \* encourage continued feeding during diarrhoea
- \* follow up of children with diarrhoea - visit several times and watch for danger signs

#### 4.3 Suggested duration and methodology:

##### (a) Initial duration 1 day

- Morning - knowledge < AM Session
  - Minilecture/group discussion
  - Exercise - preparation of charts, posters showing food contamination, signs of dehydration etc.
- Afternoon - skills : PM Session
  - Group discussion/minilecture on treatment of diarrhoea. Preparation of ORS, instruction for use follow up of children with diarrhoea
  - Role play - two families, each with a child having diarrhoea, one family follows instruction of CHV, another family does not - results in both families
  - summarize and revise lesson

(b) Continuing education - at monthly meeting, use actual case studies of diarrhoea which have occurred in the community during the month re-emphasise points in knowledge and skills required by CHV.

#### 4.4 Materials required :

- water, sugar, salt and lime for ORS demonstration
- visual aids - charts, posters, slides showing signs of dehydration
- chalk/blackboard
- paper and crayons for making posters & flash cards.

#### 4.5 How to teach this lesson

ASK:- How many children in your village have had diarrhoea in the past month

- why do you think diarrhoea is so common?
- Allow time for CHV to think of reasons.

TEACH - we get diarrhoea when we

- drink unclean water
- eat unclean food
- eat with unwashed hands
- allow flies to sit on food

ASK - So how can we prevent diarrhoea?

Allow time for CHV to give reasons.

EXPLAIN:- In hot weather

- there is less water, so people wash less
- there are more flies, so more chances of food being uncleaned
- germs grow more quickly, so there are more germs around

ASK :- Has any one in your village died from diarrhoea ?

How old were they ?

How long were they ill ?

What "treatment " was given?

ASK :-Why do you think these children/people die and others get better?

(Try to help them realise that most of those who died, died from loss of water not from the disease itself)

EXPLAIN :- BODY NEEDS WATER AND SALT

- Water and salt are lost in the stool causing dehydration = water loss.
- we can tell if a child is losing too much water if :
  1. His tongue is dry and he feels thirsty
  2. He passes less urine
  3. He is less active
  4. His eyes are sunken
  5. His skin becomes loose and takes a while to go back in place when you pinch it.

EMPHASISE:- LOSS OF WATER AND SALTS CAUSES DEATH.

WE CAN PREVENT DEATH BY GIVING ORS.

ASK :- How can we prevent loss of water and salts  
(answer by giving ORS)

DEMONSTRATE

- Preparation of ORS at home
- allow time for CHV to practice this

TEACH :- Instructions to give to mothers

- \* prepare ORS as soon as child has diarrhoea
- \* Prepare six - eight glasses at a time and keep in a covered vessel
- \* Child needs one glass per stool- so give throughout the day in small quantities.



\* Be sure to make mothers understand that ORS is not a medicine to STOP DIARRHOEA that diarrhoea may continue but the body water and salts will be replaced. So the body will not become weak.

TEACH: -Referral points

DISCUSS: -Local attitude to giving food and fluids to children during diarrhoea

TEACH : -Importance of continued feeding during diarrhoea, types of foods , to continue breast milk.

- Importance of giving extra food after diarrhoea stops.

EXPLAIN: - IMPORTANCE OF FOLLOW UP

+ CHV should enquire from a mother how a child is doing, this increases credibility and builds rapport

+ Points to check on

- is diarrhoea improving ?
- is mother preparing ORS correctly and using it?
- is child getting enough fluids?

TEACH : - DANGER SIGNS IN DIARRHOEA

- a) Child has such bad diarrhoea that it is impossible to give him by mouth all the fluids he is losing -
- b) He keeps vomiting (more than 2-3 times/day)
- c) He is drowsy - not active
- d) He does not get better in two days

EXPLAIN :- a child who is getting enough fluids will keep passing urine (at least 4-5 times/day) also his tongue will be moist, his eyes bright & shiny and his skin firm.

How to assess that CHV have learnt this lesson

- use role play. Ask one group of CHV to put on a skit playing the role of a mother with a sick child ( child of diarrhoea) and a CHV educating and teaching the mother what to do. Ask the other group to .
- observe the role play and comment whether all points in the lesson were taught including whether CHV followed-up on her instruction to the mother.

PREPARING AND DEMONSTRATING HOW TO ADMINISTER REHYDRATION MIXTURE TO INFANTS AND CHILDREN IS VERY IMPORTANT FOR TREATING DIARRHOEA AND VOMITING IN VILLAGE HOMES

## 1

1.1 \* various statistical figures give an idea of the extent of the problems in India

- Per cent distribution of households according to protein-calorie adequacy (rural)- 1980

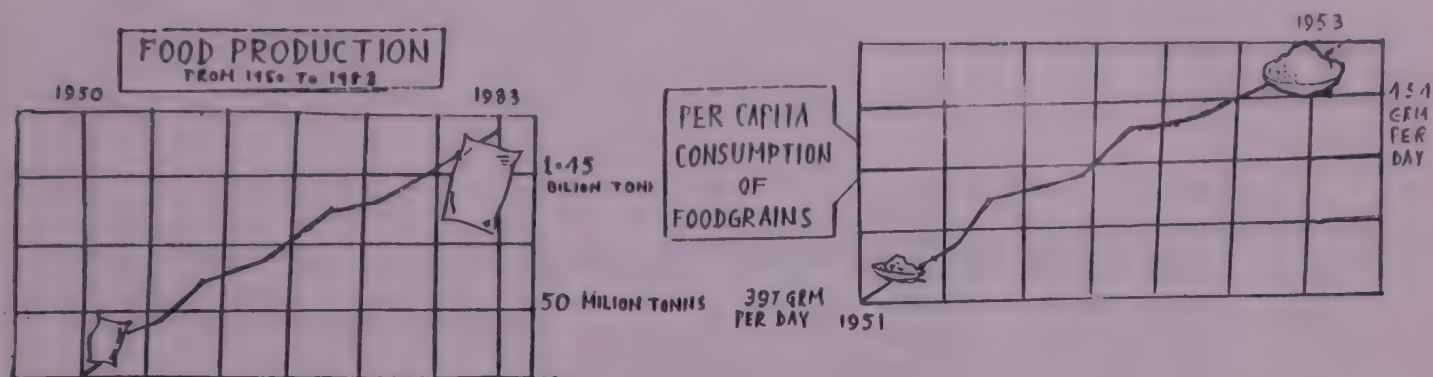
P	C	Protein and Calorie adequate;	P	C	Protein inadequate and Calorie
+	+		-	+	adequate

In urban slums (data from same source) the situation was worse - 25% of households did not meet either protein or calorie requirement 29% had adequate protein but not calories, thus 54% of households had inaequate calorie consumption.

- 90

## 1.2 Food production and Consumption

- \* India has made notable progress in foodgrain production, registering an increase from 50 million tonnes in 1950 to an estimated 1.45 billion tonnes in 1983-84, an annual increase of 3.04 per cent, well above the annual growth rate of 2.5 per cent per annum.



### Consumption:

- \* Despite this the apparent level of per capita food consumption over the past two decades has remained rather stagnant.

Per capita apparent consumption of foodgrains

-----	
Grams per day	
-----	
1951 - 53	397
1961 - 63	458
1971 - 73	452
1977 - 79	458
1980	411
1981	454
1982	454

- \* There is however a significant change in the pattern of consumption of the past three decades - there is a small increment in the per capita consumption of cereals. But intake of vegetable proteins from food grains has unfortunately declined.



## Changing pattern of food grains consumption

YEAR	Grams per day			
	Rice	Wheat	Coarse Grains	Pulses
1951 - 53	161	62	131	61
1961 - 63	197	81	116	64
1971 - 73	187	116	103	46
1977 - 79	189	124	101	44

- \* Poor consumption is related to low availability as well as poor purchasing capacity. Redressing regional imbalances in agricultural growth was proposed in the 6th five year plan a measure of improving food availability. However significant regional differences persist RAISING ISSUES OF PRODUCTIVE AS WELL AS DISTRIBUTIVE JUSTICE.

### 1.3 Malnutrition is perceived at two levels.

- \* individual and
- \* societal.

At the individual level-malnutrition refers to nutritional disorders arising from four major causes.

- i) Insufficient food intake causing hunger and consequent undernutrition through calorie as well as protein deficiency;
- ii) Qualitatively insufficient food intake causing nutrient-specific disorders such as anaemia, iodine deficiency disorders, and xerophthalmia caused by lack of vitamin A;
- iii) Malabsorption, underuse and improper use of nutrients or breaking down of body tissues due to illness or genetic or environmental condition, leading to secondary malnutrition. Typical examples are intestinal disorders and infectious diseases;
- (iv) Overnutrition leading to obesity, diabetes, hypertension and heart ailments.

While the first three are associated with poverty, the fourth is related to affluence.

The commonly noted effects of malnutrition on the individual are:

- reduced activity (saving on energy consumption);
- reduced growth of children; that is, reduced height for age (stunting) and
- reduced weight for height (wasting);
- increased susceptibility to, and more serious effects from, some infections like measles; and disorders due to nonabsorption of micro-nutrients like iron causing anaemia; poor use of vitamin A because of low energy intake leading to eye impairment and in time blindness;
- death in the case of severe and prolonged malnutrition.

Source: Analysis of the situation of children in India.

At the societal level, Malnutrition is linked to the relation of people with food. Food as a means of peoples health is linked to many factors like.

- distribution of income
- production and commercial distribution of food
- family knowledge and behaviour about the use of food
- social customs regarding food consumption within each family unit.
- epidemic and environmental diseases affecting bodily needs.
- government and community policies and services such as food subsidy to low income groups.

MALNUTRITION IS A MAJOR OBSTACLE TO HUMAN PRODUCTIVITY AND SOCIO-ECONOMIC DEVELOPMENT because of its immediate effect on health, strength and worker productivity.

#### 1.4 Vulnerable groups and government Programmes

Diet and nutrition surveys conducted by the state Nutrition Divisions and the National Nutrition Monitoring Bureau have revealed that protein-calorie malnutrition is prevalent in large sections of the population.

- The most severely affected are young children, pregnant and lactating mothers.
- The pattern of nutritional deficiency signs indicated that the most commonly encountered disorders were
  - (a) Protein, energy malnutrition PEM - children under 5 years of age
  - (b) Vit 'A' and 'B complex' deficiency - school age children adolescents and adults.
  - (c) Anaemia - pregnant and lactating mothers.

In order to overcome the problems of malnutrition in the country, the Government of India is implementing the following nutrition programmes through the various Government departments.

<u>Programme</u>	<u>Ministry</u>
1. Prophylaxis Programme (Vit A)	Ministry of Health & Family Welfare against nutritional blindness due to vit A deficiency.
2. Prophylaxis Programme (anaemia)	Ministry of Health and Family Welfare against nutrition anaemia.
3. Special nutrition programme	Ministry of Social Welfare
4. ICDS - Integrated Child Development Scheme	Ministry of Social Welfare
5. Balwadi nutrition programme	Ministry of social welfare
6. Mid day meal programme	Ministry of Education
7. Nutrition education/extension	Ministry of health, Agriculture and Food.

#### 1.5 Myths about "good nutrition" - points for discussions

- (i) a vegetarian diet is "inadequate"
- (ii) a good diet means eating meat daily or atleast twice a week
- (iii) it is impossible for low income groups to have a nutritious diet
- (iv) the trend towards eating more refined foods "white bread, noodles etc is good nutrition"
- (v) apples and grapes are very special food to eat when one is sick (they may whet the appetite and be enjoyed but are not all that high in food value and are often costly.

Could ask "which would be a better choice for your child - egg or apple ? cost is about the same - egg gives more food value for the money".

- (vi) "Hot" and "Cold" food - each community has its own perception of these.



## 2. Assessment of Malnutrition

A - in the individual

B - in the community

A - in the individual :

- a) Anthropometric measurements
- b) Biochemical
- c) Clinical
- d) Dietary

B - in the community:

- a) Anthropometric measurements
- b) Clinical - specific vit & mineral deficiency
- c) Dietary - household surveys

### Assessment of Malnutrition

#### A. In the individual child

Anthropometric measurement : Several body measurements are used to assess a child's nutrition status - viz mid upper arm circumference, weight for age, weight for height, triceps skin fold thickness, head circumference and chest circumference.

The most practical methods are

- i. Arms circumference : The child's left arm is measured at the mid-pt between the shoulder and the elbow with a tape, taking care not to squeeze the soft tissue of the arm. Ready made tapes are available from VHAI, however you can make your own measuring tape - demonstrate.



Interpretation :-

- a measurement of  $< 12.5$  cms indicates severe malnutrition
- $12.5 - 13.5$  indicates moderate malnutrition
- $13.5 - 14.0$  mild malnutrition
- $> 14.0$  cms = normal nutrition

Advantages of this methods are :

- correlates well with weight and weight for height
- quick and easy method therefore useful in surveying communities
- minimal "equipment" required
- minimal training required

Disadvantages :

- not very reliable in serial monitoring of nutritional status children

CHECK BY USING ARM CIRCUMFERENCE TAPE

One end of this tape is black

The tape has green, yellow and red strips over it.

This tape is used to measure the arms of children one to five year.



GREEN - Well nourished

13.5cm

YELLOW - Slightly undernourished

12.5

RED - Malnourished

BLACK -  
0 CM

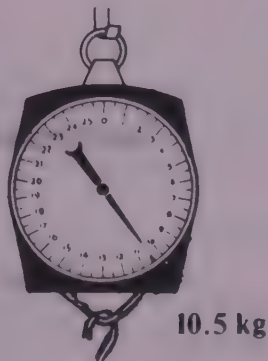
Measure the mid arm with tape:

- \* If black end touches the green - good health
- \* If it touches the yellow - border line nutrition Take remedying measures, advice in details about nutrition.
- \* If it touches the red - very poor nutrition Refer to sub-centre immediately.

REMARK: Easy method which gives fair idea of child's nutrition

Easy to learn.

- ii) Weight for age - it is an indicator of Protein Energy Malnutrition or growth failure in young children. It involves weighing of children and knowing their ages. Assessment is done by the comparing the weight with a standard (50th percentile of Harvard standards) degree of malnutrition is classified by Gomez as follows.

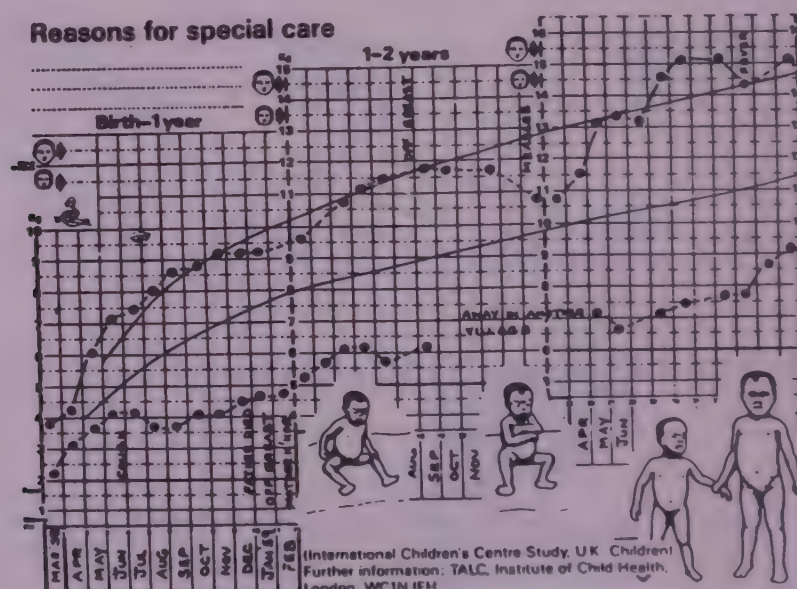




MILD first degree - 90 - 75% of standard  
 MODERATE second degree - 75% to 60%  
 SEVERE third degree - <60%

#### Use of the Card:-

Charts showing the normal weights against age are available. One such chart is printed on ROAD TO HEALTH CARD (yellow card) recommended for use in maintaining a record of weight, as well as other relevant information such as family size, immunization record etc. One side of the card shows weight plotted against age. A shaded area on the chart depicts the "normal" weight of the child. Three areas marked by interrupted lines below the shaded area show the varying degrees of malnutrition. i.e. first, second and third degree or mild moderate and severe malnutrition. These cards are available (in different local languages) from Voluntary Health Association of India, Delhi.



#### Clinical Methods

Clinical signs of specific deficiencies which may occur alone as is usually the case, especially in children, along with the signs of general malnutrition PEM, i.e., protein energy malnutrition.

#### Signs of specific deficiencies

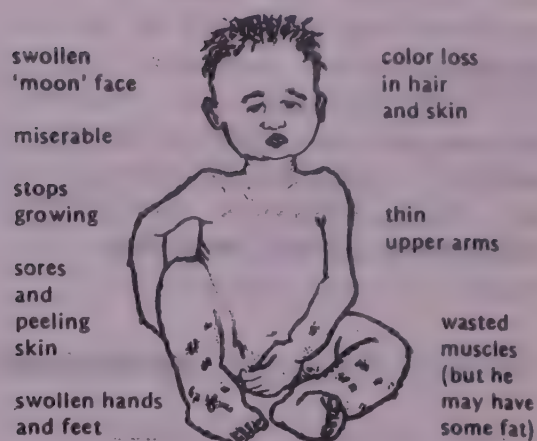
- signs of anaemia - paleness, tiredness
- signs of B complex deficiency - sores at the angles of the mouth
- signs of Vit A deficiency - night blindness, dryness of the conjunctivation
- signs of iodine deficiency - swelling in front of the neck.

Signs of PEM - (protein energy malnutrition, i.e. deficient intake of protein and calories)

DRY MALNUTRITION  
OR MARASMUS  
—from not eating enough—



WET MALNUTRITION  
OR KWASHIORKOR  
—from not eating enough protein—



- (i) Weight loss
- (ii) apathy - mood changes
- (iii) skin changes
- (iv) hair changes
- (v) Weight "gain" due to OEDEMA - swelling
- (vi) clinical appearance of MARASMUS and KWASHIORKOR i.e. extreme conditions of protein calorie deficiency

Dietary assessment: The steps involved in dietary assessment include

- 1) a record of food intake
- 2) conversion to nutrient value
- 3) consideration of factors which may effect absorption
- 4) comparision with standards

Special training is required to perform Dietary assessment.



## Assessment in the community

Anthropometric measure - The most practical use of the arm s circumference in children 1-5 yrs of age. This gives a rapid assessment of the number of malnourished children in the community.

Clinical signs - such as signs of anaemia or Vit A or B deficiency also allow us to get an overall picture of the extent and type of malnutrition in the community.

## Dietary:

Household surveys which attempt to get an overall impression of dietary habits, intake and nutrient value of either selected groups in the community or a cross section of the entire community. These are time consuming and do require some training but can yield valuable base-line data of the nutritional status of the community.

## Indirect Assessment of Nutrition Status:

- age specific mortality rates - esp 1-4 year mortality rate which is high in developing countries due to a combination of infections, parasitism and malnutrition during this period characterised by rapid growth and high nutritional needs.
- morbidity and cause specific mortality.
- frequency of illnesses

## 3. Correction of Malnutrition:

### A. In the Individual

#### \* Prevention:

- prolonged Breast feeding - upto 2 years
- avoidance of Bottle feeding
- Introduction of weaning foods by six months of age.
- feeding during illness.
- increased feeding immediately following illness.
- prompt use of ORT in diarrhoeal infections
- use of a balanced diet in the house.

#### \* Treatment:

- correction of specific deficiencies with appropriate DIET and medications
- severe cases of PEM may require treatment in a medical facility.



## B. In the Community:

- measures to ensure food availability
- encouraging use of kitchen gardens - grow at least one vegetable
- health education regarding Nutrition especially for vulnerable groups and discussion of "food myths" existing in the community.

### NORMAL GROWTH OF THE BABY IS AFFECTED BY MALNUTRITION

i.e. a baby's weight starts falling instead of rising steadily.

- This can be picked up if the weight of a child is taken regularly and recorded on a chart such as the road to health card.

for eg: (follow this example on your sample card) egg + 50 g meat or fish

a baby at birth weighs	3.0 kg
at 3 months weighs	5.0 kg
at 6 months weighs	6.5 kg
at 9 months weighs	7.5 kg
at 1 year	8.0 kg
at 15 months	8.5 kg

You will note that at this point (i.e.) at 15 months the child's weight is beginning to fall, this is point to intensify nutrition education i.e. the CHV must give this family special attention.

Experience has shown that one's health workers can grasp the progress in weight as an upward trend indicating adequate nutrition. However the educational process required before actually using cards must not be underestimated. ALLOW A PERIOD OF 6 months to one year before staff really understand and appreciate their use.

Use of this method requires trained personnel and equipment which must be checked regularly for accuracy

- (iii) Height for age: the extent of height deficit in relation to age may be regarded as a measure of the duration of malnutrition. Older infants and children (above age 3 yrs) or measured by standing (without shoes) against a vertical rod or scale fixed to the wall. Young children or best measured lying down.

Use of this method also requires trained personnel.

- \* Anthropometric measurements such as triceps skinfold thickness, head chest measurements are more difficult to obtain and require both skill and special equipment.

### Biochemical methods

Involves laboratory measurements ranging from relatively simple tests to more complex ones which are therefore impractical for use in monitoring



(i) Haemoglobin % estimation

(ii) Serum proteins < Total  
Albumin/Globulin

(iii) Serum vitamin A levels, serum carotene

(iv) Serum alkaline phosphatase (Vit D)

- of these Haemoglobin % estimation may be possible at field level.

3.3 Dietary requirements for the family and for vulnerable groups including pregnant and breast feeding mothers and children 0-2 years.

Tables 1,2,3 & 4 give the actual requirements of the various foods necessary for optimal nutrition.

TABLE - 1

BALANCED DIETS

Food Item	Adult Man			Adult Woman			Children	
	Seden tary	Mode rate	Heavy work	Seden tary	Mode rate	Heavy work	1 - 2 years	4 - 6 years
Cereals	460	520	670	410	440	575	175	270
Pulses	40	50	60	40	45	50	35	35
Leafy vegetables	40	40	40	100	100	100	40	50
Other vegetables	60	70	80	40	40	100	20	30
Roots and tubers	50	60	80	50	50	60	10	20
Milk	150	200	250	100	150	200	300	250
Oil and Fat	40	45	65	20	25	40	15	25
Sugar or Jaggery	30	35	55	20	20	40	30	40

TABLE - 2

## SUGGESTED SUBSTITUTION FOR NON-VEGETARIANS

Food item which can be deleted from non-vegetarian diets	Substitution that can be suggested for deleted item or items
50% of pulses (20-30 g)	1. One egg or 30 g of meat or fish 30 g of meat or fish  2. Additional 5 g of fat or oil
100% of pulses (40 - 60 g)	1. Two eggs or 50 g of meat or fish or one egg + 30 g meat or fish  2. 10 g of fat or oil

TABLE - 3

## ADDITIONAL ALLOWANCES DURING PREGNANCY AND LACTATION

Food items	During pregnancy	Calories (Kcal)	During lactation	Calories (Kcal)
Cereals	35 g	118	60 g.	203
Pulses	15 g	52	30 g.	105
Milk	100 g	83	100 g	83
Fat	--	--	10 g	90
Sugar	10 g	40	10 g	40
	Total	293		521

TABLE - 4

BALANCE DIET FOR 1-2 YEAR CHILD

I. Cereals	150 gms	eg. 60 rice
Gurh	15 gm	90 wheat
Oil, Ghee	11 gm	
II. Milk	250 gm	
Dal, Groundnut	50 gm	



(i) Haemoglobin % estimation  
 III. Green vegetables

50 gm

(ii) Serum proteins  
 Total  
 Other vegetables and fruit as budget allows  
 Albumin/Globulin

How to use these tables - make your own notes during class demonstration.

(iv) Serum alkaline phosphatase (Vit D)

Table 1.12 shows the nutrient requirements of the National Institute of Nutrition for optimal nutrition.

#### BALANCED DIETS

Food Item	Adult Male			Adult Female			Children	
	Sedentary	Moderate	Heavy	Sedentary	Moderate	Heavy	1 - 2 years	4 - 6 years
Cereals	460	520	670	410	440	575	175	270
Pulses	40	50	60	40	45	50	35	35
Leafy vegetables	40	40	40	100	100	100	40	50
Other vegetables	60	70	80	40	40	100	20	30
Roots and tubers	50	60	80	50	50			
Milk	150	200	250	100	150			
Sugar or Jaggery	30	35	55	20	20			

## Some low cost nutritions receipes and tips:

### 1) High Protein Mix:

Ragi or wheat	- 1 kg
Green grain dhal - or Bengal gram dhal	- 1/2 kg
Ground Nuts	- 1/4 k
Jaggery	- 1/2 - 3/4 kg.

Roast first two ingredients and grind to a powder. Powder groundnuts (after roasting) and Jaggery at home. Mix two powders well and keep in an air tight tin. Use 2 heaped table spoons of powder per glass of water, mix and cook for approximately 5 minutes on low fire to make a kanjee or porridge. Use as a nutrition supplement (i.e. in additon to regular food) twice daily. May be used for all in the family but more important for children 1-5 years and pregnant and lactating mothers.

2) Mixing green grain dhal or Bengal gram powder (1:2) with wheat flour will make more nutritions chappatties or rotis, also green leafy vegetables can be mixed into the dough.

### 3) Ragi Malt:

- wash and clean required amount of ragi
- soak over night in double the quantity of water.
- drain and spread wet ragi on a clean cloth, cover with thin cloth & leave in shade
- keep upper cloth moist by sprinkling water
- in 2-3 days ragi will sprout - once sprout is seen allow ragi to dry.
- rub dry ragi gently between hands this will dehusk the grain.
- grind to a fine powder and store in air tight container
- make a porridge or drink - with milk or water.

### 4) Dehydration of Leafy Vegetables.

\* Leafy vegetables, since not available throughout the year at all places can be dehydrated and used whenever required.

\* when available at low cost, they can be purchased in bulk - cleaned - washed and spread on a clean sheet to dry in the shade. when completely dry these can be powdered coarsely by hand and stored in air tight containers for use when fresh supply is not available.

\* dehydrated green leafy vegetables can be added to all "curries" vegetable preparations and even in dosai or chappati dough to increase the nutritive value of the food.

5) Sprouting of grams increases their nutritive value - serve lightly seasoned.

Comparision of home preparations and commercially available foods.

Home preparation cost per 100 gms		Commercial available cost per 100 gms	
High Protein	0.80	Cerelac	4.00
Mix gram Payasam	1.50	Farex	4.00
Ground Nut Toffee	1.00	Complan	6.00
Egg	1.00	Nutramul	3.80

#### 4. Prevention of Malnutrition

##### 4.1 Diet during pregnancy.

Diet of the mother affects birth weight of the baby. Low birth weight is a sign of poor growth of the baby before its birth.

##### AMONG LOW BIRTH WEIGHT BABIES:-

- DEATHS ARE HIGHER DURING THE FIRST DAYS OF LIFE.
- THERE IS A GREATER RISK OF INFECTIONS.

If the mother`s diet is not adequate for the needs of the growing baby in her womb then nutrients are removed from the mother`s body, impairing her health and making her prone to malnutrition and infections.

#### I. DAILY FOOD REQUIREMENTS FOR PREGNANTMOTHER

II. Milk, curds	325 g	225 g
Pulses, groundnuts	60 g	45 g
Flesh foods or eggs	-	60 g
III. Fruits	30 g	30 g
Green leafy vegetables	150 g	150 g
Other vegetables	125 g	125 g



How to make this possible for low income groups.

The major area of deficiency will be in the food group of Milk and Milk Products. This can be corrected by using porridge made from "High Protein Mix" (described in low cost nutrition recipes) twice daily. Other items mentioned in low cost nutritious recipes can also be used especially during pregnancy .

#### 4.2 DAILY REQUIREMENT FOR LACTATING MOTHERS:

Breast feeding imposes a greater strain on the mother`s body than pregnancy. Additional body building foods and energy foods are needed to produce and secrete milk.

IT IS MORE ECONOMICAL TO PROVIDE THE MOTHER WITH A GOOD DIET SO THAT SHE CAN PRODUCE ADEQUATE MILK FOR THE BABY, THAN TO BUY MILK OR POWDER MILK FOR THE BABY.

#### BALANCE DIET FOR LACTATING MOTHER

<u>FOOD GROUPS</u>	<u>VEGETARIANS</u>	<u>NON-VEGETARIANS</u>
I. Cereals	400 g	400 g
oil, ghee	50 g	50 g
Sugar, gurh	50 g	50 g
II. Milk, curds	325 g	225 g
Pulses, groundnuts	70 g	55 g
Flesh foods or eggs	-	60 g
III. Fruits	30 g	30 g
Green leafy vegetables	150 g	150 g
Other vegetables	125 g	125 g

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#### 4.3 Diet during the first 2 years of life:

ITEM	AGE
i) Breast-feeding by mother	0-2 yrs
ii) Add other food supplements gradually such as: porridge. potatoes, bananas, other cooked fruits eggs, dhals then:	beginning at 4 months or after rice feeding ceremony (6-7 months) till 1 year

Spinach, green vegetables, ground nuts, beans, meat milk, curds.

The safest way of feeding is with cup or plate and spoon or with clean hands.



- iii) Modified (made soft and without much spices) adult food in addition to what the child has already been eating

one year and after

Small children should be fed often, 4-5 times daily, as their stomachs are too small to absorb bulky foods in two meals a day.

## BREAST MILK

- Breast milk is the natural food for babies and especially suited for them.
- It contains everything a baby needs for health and growth
- Protects against infections and diseases.
- Always available, fresh at a right temperature
- Always clean, free of germs.
- Easy to feed. No preparation required, it is cheap.
- \* Breast feeding helps to create a close relationship between mother and baby.
- \* Breast feeding helps prevent pregnancy, but do not rely completely on this method, PRACTICE FAMILY PLANNING
- \* Breast milk alone is sufficient 4-6 month.



## BOTTLE MILK

- Expensive to give in the strength needed for growth of baby.
- Preparation is difficult
- A bottle is difficult to clear and keep free from germs
- It is expensive, expense of bottle, milk fluid, time etc.
- If the bottle is not clean and boiled properly it can cause serious infections in the baby.

\* DO NOT USE BOTTLE





## SOME MOTHERS ARE NOT ABLE TO FEED THEIR BABIES

Because :

- \* Mother may have died
- \* Mother may be very sick
- \* Mother is not able to produce breast milk, the main reason for this is inadequate diet.
- \* Or some other reasons

In this case,

- Give some other mother's breast milk,
- If not possible, give cow's or buffalo's milk, which has been boiled, with cup and spoon.



### FEEDING THE SICK CHILD

THIS REQUIRES TIME AND EXTRA EFFORT INVOLVED IN MAKING FOOD WHICH THE CHILD WILL ACCEPT.

SICK CHILDREN HAVE TO BE COAXED TO EAT.

EXTRA FEEDING IS VERY IMPORTANT IMMEDIATELY FOLLOWING ILLNESS.

### 5. Sources of Nutrition Information

1. National Institute of Information, ICMR Osmania P.O. Hyderabad Andhra Pradesh 500 007.

Publications : (1) Nutrition - quarterly - cost/yr. Rs 2.00  
(English)

(2) Poshan (Hindi) quarterly - cost/yr Rs 4.00

Request - Nutrition Notes- Published Bimonthly (no charge)



— Breast milk is the natural food for babies and especially suited for them.

DO,s

DONT`s

Breast feed: Start within first 2-3 hrs of birth. The first milk is very beneficial to the baby, as it contains substances that protect the baby from disease.

\* DO NO GIVE POWDER MILK

#### Useful reference books

1. Nutritive value of Indian food .. Rs 9.00
2. Recommended - Dietary Intakes for Indians .. Rs 4.00
3. A list of current publications, some of which are free are available at the following addresses

#### I. NIN -

National Institute of Nutrition Hyderabad

#### II. UNICEF

Regional Office for South Central Asia,  
UNICEF house, 73 Lodhi Estate  
New Delhi 110 003

- A small voice - pamphlet about health and nutrition
- Ideas forum
- Many publications are available - you could write for information request gratis publications.
- Future (4 issues per year) subscription Rs 30/-

### III. Nutrition Foundation of India

Dr C. Gopalan - B - 37 Gulmohar Park, New Delhi 110 049

- NFI Bulletin - request to be on mailing list
- other reports available - Scientific Reports
- 1. The National Goitre control Programme
- 2. Nutritional and Health Education through the Rural School System.
- 3. Infant feeding practices with special reference to the use of commercial infant foods.

IV. WHO - WHO Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, New Delhi 110 002

World Health : Published 10 times per year- Often Nutrition - related articles Write for list of publications available

### V. Central Health Education Bureau, (Government of India)

Kotla Marg, New Delhi 110 002

Publication & posters are available from this office.

Swasth Hind (English) - Published monthly, subscription Rs 3.00

### VI Voluntary Health Association of India

70 Institutional Area, Near Qutub Hotel, south of I.I.T., New Delhi 110 016

Write for list of publications, posters, visual aids, etc., available.

### 6. Management of malnutrition at field level

Refer Annexure

### 7. Guidelines for teaching CHVS

Content:

CHV needs to know:

- definition of malnutrition
- some facts and figures about malnutrition and its causes
- knowledge of basic food groups and their nutrient value.
- signs of malnutrition and assesment.
- relationship between malnutrition and infection.
- prevention of malnutrition
- importance of good nutrition during pregnancy and lactation.
- some low cost nutrition
- recipes



CHV needs to do:

- identify children and mothers with malnutrition.
- educate pregnant and lactating mothers about their diet
- encourage mothers to breastfeed
- teach mothers about supplementary and weaning foods.
- encourage the use of "kitchen gardens"

Duration: Initial 2 days followed by re-emphasis and revision during MCH clinics

Methods/Materials:

- group discussion/lectures
- charts/posters, slides
- demonstration
- assignments

DEMONSTRATE:

Food portions for pregnant and lactating feeding mothers.

ASK: CHVs if portions shown are feasible for low-income families in these communities.

Within available resources - diet can be improved by

- using 2 different kinds of cereals daily eg. rice + ragi or rice & wheat
- using sprouted dehydrated grams.
- using green leafy vegetables daily.

HOW TO TEACH SKILLS REQUIRED.

(1) Identification of signs of malnutrition.

- show pictures on slides and ask CHVs to identify various signs
- ask CHVs to help each other identify various signs in their own communities

(2) Educate pregnant and lactating mothers about their diet, teach about supplementary or weaning foods, importance of breastfeeding. CHVs can role play, others in the group can observe and comment on the points mentioned/not mentioned. CHV can demonstrate preparation of high protein mix.

(3) Encourage the use of "kitchen gardens"

- help in planting drumstick and/or papaya trees,
- mint can be easily grown in a pot or old cigarette tin.

## Malnutrition:

### Definition:

- \* simply means improper nutrition
- \* the body needs foods of a certain quality and quantity for:
  - (a) growth
  - (b) day to day functioning
  - (c) energy for work
  - (d) to store for time of stress.
- \* certain groups have more food requirements because of rapid growth, eg. children - especially below 5 years, pregnant mothers
- \* people who work more also need more food.
- \* if the body does not get the right amount and the right quality of food it becomes "weak" or malnourished.

Some facts and figures about malnutrition and its causes.

- \* In India 85% of children are undernourished
- \* this results in high death rate in children 1-5 years of age.
- \* 80% of pregnant and lactating women are anaemic - i.e. have "less blood".

### Causes:-

- \* get the group to express their views on causes.
- \* point out that:

POVERTY

IGNORANCE > all play a role in causing malnutrition.

INFECTIONS

- \* give examples how each of these three factors has an impact on nutritional status.
- \* knowledge of the basic food groups.

The foods we eat are divided into 3 groups depending in their use to the body.

#### Group I - Energy-giving food

- cereals - i.e. all grains and millets, rice, wheat, ragi etc.
- sugar, jaggery
- fats, oils & nuts.

## Group II - Body - Building Foods

All kinds of meats, fish, egg, milk & milk products, Pulses - all dhals, legumes - peas, beans, groundnuts.

## Group III - Protective Foods

Fruits and vegetables, especially green leafy vegetables.

- \* Our daily diet must contain one or more foods from each group.
- \* EAT GREENS DAILY.
- \* SIGNS OF MALNUTRITION.

Show a healthy and a malnourished child if possible or show charts, posters or slides showing these.

Assessment:

Teach how to make and use arm circumference handbook.

### \* Relationship between malnutrition & infection

- + ask which children are always sick
- + are these children strong & healthy looking or weak & puny?
- + teach that the body fights infection if it is well nourished -
  - this is why children who are well nourished FALL SICK LESS OFTEN AND also RECOVER FROM ILLNESS MORE RAPIDLY.

### MALNUTRITION

UNABLE TO EAT  
DURING INFECTION

<----->

"WEAK" BODY SO  
MORE INFECTIONS

Importance of good Nutrition during pregnancy and lactation.

### TEACH

- \* a pregnant mother needs more food so that the baby can grow properly.
- \* babies who are born small, i.e. low weight have more chances of dying
- \* babies who are born small, also fall sick easily.
- \* to avoid having small babies the mother must eat well during pregnancy
- \* a mother's who is breast-feeding must eat sufficient food.
- \* if mothers food intake is less she will not produce enough milk for her baby

DEMONSTRATE:

Food portions for pregnant and lactating mothers.



## VITAMIN A

### 1. The problem:

#### 1.1 Extent of the problem

- \* Government of India estimates 30,000 children are becoming blind each year from Vit A deficiency.
- \* National Nutrition Monitoring Bureau found Vit A deficiency of all families from infants to 12 years old (1981).

States	0-1	1-5	5-12	
			Boys	Girls
Kerala	Nil	Nil	Nil	Nil
Tamilnadu	1.4-1.5 %	Nil	Nil	Nil
Karnataka	1.4-1.5 %	7.2 %	17.4 %	11.5 %
Andhra Pradesh	1.4-1.5 %	8.6 %	17.4 %	11.5 %
Gujarat	Nil	Nil	20.5 %	15.7 %
Orissa	Nil	7.2 %	15.1 %	Nil
West Bengal	Nil	2.9 %	9.6 %	11.5 %
Uttar Pradesh	Nil	Nil	5.5 %	4.2 %

#### 1.2 Signs of deficiency

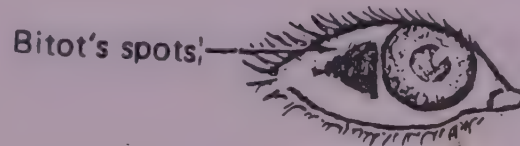
- a) NIGHT BLINDNESS - one of the earliest signs of deficiency which precedes physical changes and can be reversed with Vit A treatment. An observant mother may remark that her child stumbles around in the dark.



- b) DRYNESS OF THE CONJUNCTIVA - the conjunctiva appears dry, not shiny and there may be a brownish discolouration of the normally white portion of the eye. This can also be treated with Vit A administration.



- c) BITOT'S SPOTS - foamy whitish, oval or triangular spots usually on the outer white portion of the eye - treatable with Vit A.



- d) PHOTOPHOBIA - a tell-tale sign of Vit A deficiency easily demonstrated by moving a child from subdued lighting (inside a room) to direct sunlight - a child with Vit A deficiency (among other illnesses) will be unable to fully open its eyes.
- e) Drying of the cornea - ( clear part of the front of the eye ) - lacking its normal shine. This is still a reversible stage but if unchecked leads to progressive damage and complete destruction of the eye.
- f) Ulceration of the cornea - loss of part of the surface of the cornea - can be partly reversed if caught in time if not it can result in destruction of the cornea and blindness.
- g) Complete destruction of the cornea and other tissues of the eye - infection almost always follows within a few days - the other eye can also be involved leading to TOTAL IRREVERSIBLE BLINDNESS ALL FOR THE WANT OF VITAMIN A - which is easily available in its precursor form (carotene) in green and yellow vegetables.

### 1.3 Relationship of Vit A deficiency and overall child health (State of the World's Children, 1986)

- \* although the relationship between xerophthalmia and severe Vitamin A deficiency has been clearly established, only one large scale study so far has looked at the relationship between the lack of Vit A and overall child health. For an 18 months period, 4,000 Indonesian children aged 1-5 years were given health checks once in three months - health records from over 20,000 such visits were assembled and the differences in the health records of the children with and without signs of Vit A deficiency were analysed.

## 2. The Solution :

### 2.1 The Government Programme :

- \* The National Programme for Control of Blindness initiated in 1976 aims at reduction in incidence of blindness from 1.4% in 1982 - 83 to 0.3% in 1999.
- \* At present ANM's and other paramedical workers distribute the vitamin in the form of flavoured syrup once in 6 months to children 1-5 yrs of age during their home visits and maintain a record of their distribution.
- \* An evaluation of this programme was undertaken by the National Institute of Nutrition in the State of Andhra Pradesh, Gujarat, Karnataka, Kerala, Maharashtra, Orissa, Rajasthan and West Bengal. This evaluation covering over 70,000 children in 58 sub-centres reported the following main findings:
  - (i) a low coverage of only 50 percent
  - (ii) inadequate records of supplies and distribution of Vit A
  - (iii) reasons for poor coverage were
    - irregular and short supply of the vitamin
    - lack of preparation of the community
    - disturbed work schedule of the ANM due to family planning work
    - lack of supervision

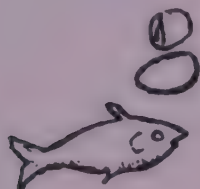
The evaluation report concludes - " This programme was conceived as a short term measure..... until such time as the most rational and permanent solution takes over - improving the intake of Vit A through the habitual diet."

- \* UNTIL THE SHORT TERM MEASURE IS COUPLED WITH CONCURRENT ENERGETIC ACTION TO PROMOTE THE LONG TERM OBJECTIVE, THE PREVALENCE OF BLINDNESS due to Vit A deficiency will remain.

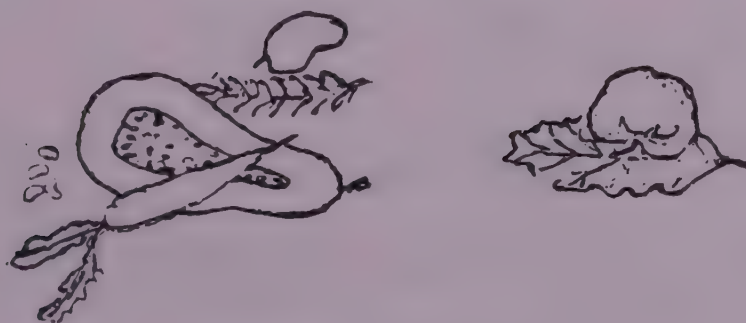


## 2.2 Foods rich in Vitamin A:

- A - Non-vegetarian - egg  
- liver  
- butter  
- fish



- B - Vegetarian - all green & yellow vegetables



- An average daily intake of 50 gms of green vegetables provides the required amount of Vitamin A for building up of the vitamin in the body to provide for the lean seasons.
- 100 gms intake of a mixture of green leafy vegetables by pregnant and lactating women will ensure adequate stores for the infant at birth.

### UNITS for Vit A activity

The usual practice is to express Vit A value of a food stuff in terms of international units of Vit A. In vegetable foods the carotene content is usually converted to Vit A in the body assuming that  $0.6 \mu\text{g}$  of carotene = 1 I.U. of Vit A

The values for Vit A are also given as  $\mu\text{g}$  of retinol

$0.3 \mu\text{g}$  of retinol = 1 I.U. of Vit A

\* I.U. = International Unit

### (3) Guidelines for teaching CHV.

#### 3.1 CHV needs to know,

- \* In India 30,000 children go blind each year from Vit A deficiency.
- \* Signs of Vit A deficiency
- \* Vit A prophylaxis
- \* Food sources of Vit A

#### 3.2 CHV needs to do,

- \* Look for early signs of deficiency
- \* Educate mothers to use greens daily

#### 3.3 How to teach this lesson :

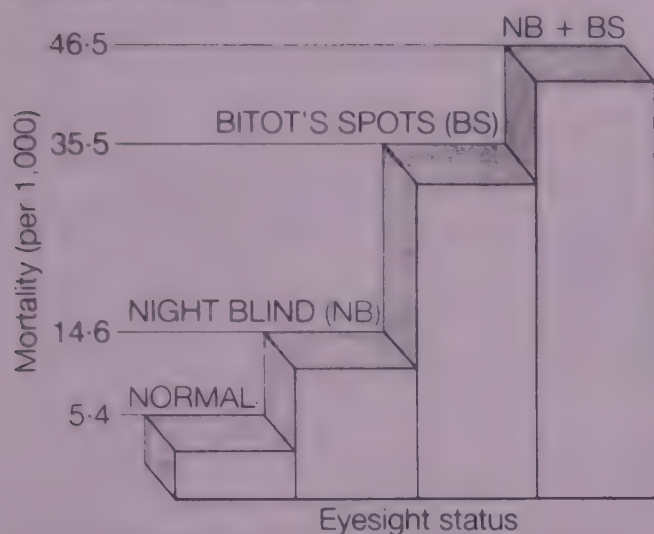
- ASK - if there are children with "night blindness" in the community  
- explain the term night blindness.

Allow time for CHVs to think, stimulate them to respond if necessary.

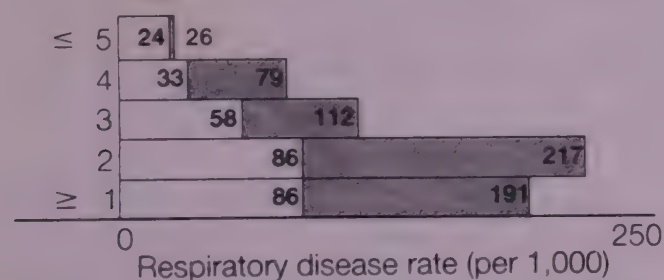
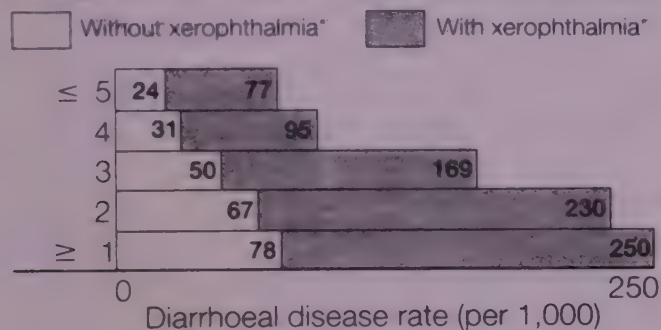
- ASK - the thoughts of the CHV's as to the possible causes of the condition.

- EXPLAIN - Vit A has a protective function - preserving the tissues of the eye so that vision remains intact.
- Therefore a lack of the Vit A in our food leads to destruction of the eye and causes BLINDNESS.
  - In India 30,000 children go blind every year as a result of lack of Vit A.
  - Why is this ?
  - Is Vit A difficult to find ?
  - Where can we get enough Vit A ?  
in our daily diet by eating foods that contain this vitamin.
  - Explore possible food myths that exist regarding these foods i.e. "hot" and "cold" foods.
  - Explain that CHV must learn to respect these ideas - and substitute another source if the community feels strongly about one particular food - eg. if drumstick leaves are considered "hot" substitute another green leafy vegetable as an equally good source.
  - Explain the Govt. programme involves:

**Chart A Mortality rates in relation to eyesight status, (indicator of vitamin A status)**

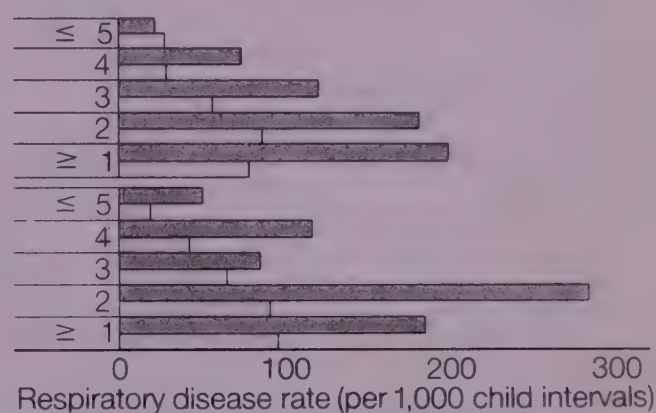
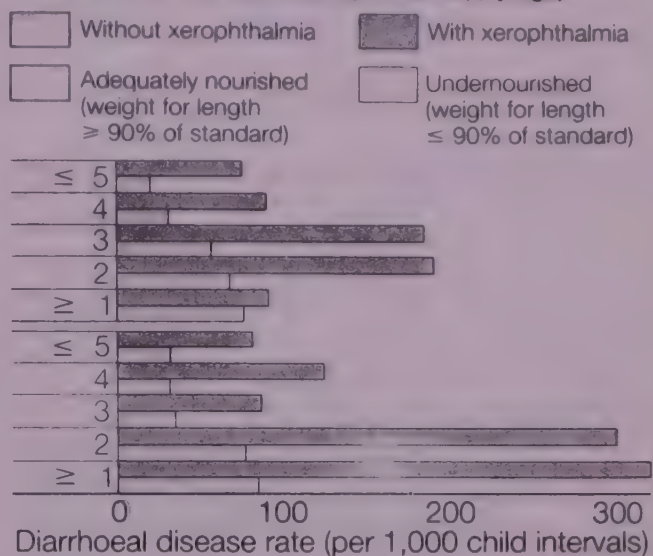


**Chart B Incidence of diarrhoeal and respiratory disease among children with and without xerophthalmia, (by age)**

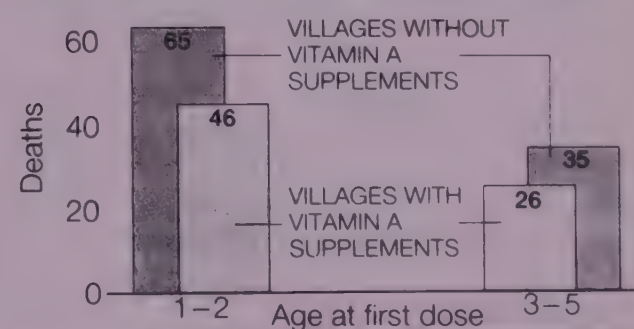


\*Without xerophthalmia = Children with normal eyes at both the start and end of the 3 month observational interval.  
With xerophthalmia = Children with mild xerophthalmia (night blindness and/or Bitot's spots) at both the start and end of the interval.

**Chart C Incidence of diarrhoeal and respiratory disease among adequately nourished and undernourished children with and without xerophthalmia, (by age)**



**Chart D Age-specific mortality, (preliminary results)**





(a) Education about food sources of Vit A

(b) Giving Vit A by mouth to children 1-5 years of age 200,000 units  
once in six months.

- Summarise and review the main points in the lesson.

3.4 Suggested duration ... 0.5 day

3.5 Method/Materials ... - Group discussion/Minilecture  
- Charts/slides showing signs of Vit A deficiency  
- demonstration - green and yellow vegetables  
- Vit A solution or capsules.

3.6 Assessment ... Question/answer

Observation of participation during  
revision session.

(4) How to manage Vit A prophylaxis at village level

As PM you should know that

(i) Vit A solution can be obtained

- from DHO office

READ THE LABEL TO SEE THE CONCENTRATION. Government supply usually  
contains 100,00 units/ml A 2 ml spoon is supplied with the bottle.

- from the chemist

again read the label to make sure of the strength.

The dose is 200,000 units every 6 months

ii) FS should be instructed to give Vit A in the dose recommended  
(200,000 units every 6 months) TO ALL CHILDREN 1 - 5 years of age

YOU COULD GIVE VIT A TO ALL CHILDREN IN YOUR PROGRAMME IN JANUARY  
AND JUNE EACH YEAR.

5) SUMMARY:

- 30,000 children go blind each year from Vit A deficiency
- This blindness can be totally prevented by giving Vit A  
200,000 units once in 6 months
- EDUCATE ABOUT FOODS RICH IN VIT A.

SECTION III

WOMEN AND HEALTH

1. WOMEN'S HEALTH AN INTRODUCTION
2. CARE OF WOMEN DURING PREGNANCY
3. CARE OF WOMEN DURING DELIVERY
4. CARE OF WOMEN AFTER DELIVERY





## WOMEN'S HEALTH

### 1. The role and status of women

#### 1.1 Folk Tale from Kenya

Here is a folk tale from Kenya which aptly describes the role of the Indian women in family and society. Once upon a time very long ago God needed some one to help him with some work that he wanted to have done. He turned to women who already had their hands full even in those days. Just when they were sitting making milk jugs and water basins and mats to cover the huts God summoned them, "come here I shall send you on an important mission. The women replied, "Yes we are coming but wait a moment, we shall just finish our work here. After a while, God summoned them again. Wait a moment, we are nearly done. Let us just finish our mats and jugs, "said the women."

The men did not have to milk, nor clean homes, fetch wood and water as the women did; their only duty was to put up a fence and protect the livestock. So since the moment they had nothing else to do, they came running at God's call and they said, "send us instead father". Hereafter, women, your chores never will be done. When one is completed the next will be waiting for you. The men may rest well as they came at once when I called but you women will have to work and toil with neither pause nor rest till the day you die. AND SO IT HAS BEEN EVER SINCE.

#### 1.2. The economic contribution of women:

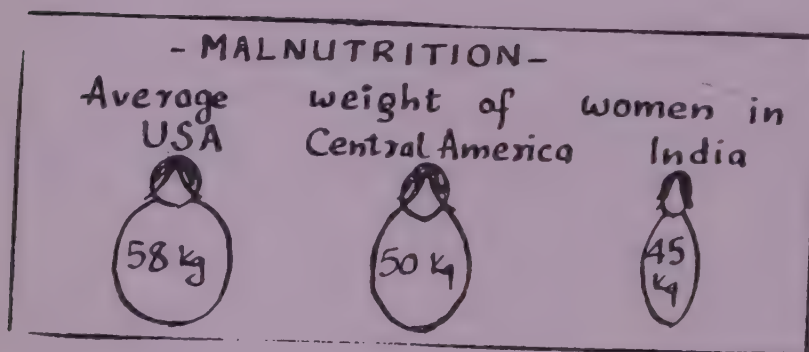
The fact that women in India contribute considerably to the national and family economy and this contribution is not accounted for (it is taken for granted). There are few opportunities for women to gain training, credit or paid employment.

#### 1.3 Women's chores:

Social tradition, customs and economic necessity keep women tied to household responsibilities and children, they are also busy in the fields gathering fodder or fetching water, women are rarely visible at meetings and community gathering which are mostly attended by men.

## WHAT THE RURAL WOMAN DOES

- Prepares the fields
- Plants crops
- Transplants seedlings
- Weeds fields
- Harvests
- Irrigates
- Selects seeds
- Processes grains
- Prepares food
- Washes dishes and clothes
- Cleans the house
- Collects and carries water
- Gathers fire wood, and makes Cow-dung cakes for fuel
- Takes care of the families
- Takes care of the animal
- Does a number of other chores



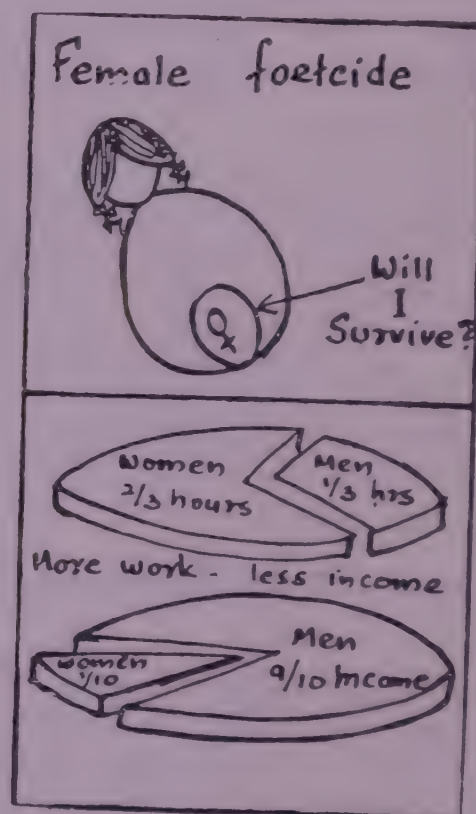
## WHAT SHE RECEIVES

Low paid job, an overworked childhood.

Inadequate diet and heavy work load for pregnant mothers.

Early marriages, care of children.

Many and close pregnancies and care of children.



VOICE... The Journal of the EMFI

## 2. The Health of Women

The health problems of women in our country are primarily related to her social status in society. This factor of social status is important irrespective of the economic group to which the women belongs. In the case of women from poorer families the risk due to being female are added to the already present risks of poverty.

### Women's health in India - Some facts

- \* Most Indian women are anaemic
- \* The general standard of living and the social status of women is very low

- \* Most women are illiterate and malnourished
- \* Repeated child births and short spaces between the birth make women more susceptible to diseases. They also have little time to take care of their own health and the health of their families.

- \* Women are over worked.

They cannot cope physically with all their responsibilities on their shoulders and as a result it affects their health.

- \* Women lead a life of drudgery, their daughters continue to do the same.

### 3. Some important reasons for the low health status of women in India

#### 3.1 Nutritional status

- Several studies in India have shown the difference in the nutritional status of female children as compared to male children of the same age.

#### COMPARISON BETWEEN THE NUTRITIONAL STATUS OF MALE AND FEMALE CHILDREN

	Normal nutrition		70-80% of the expected weight for age		Less than 70% of the expected weight for age	
	M	F	M	F	M	F
Privileged	86%	70%	10%	11%	4%	13%
Under-privileged	43%	26%	43%	24%	14%	50%

#### 3.2. Utilization of Medical services

- Women utilise health services much less than males.

#### UTILIZATION OF MEDICAL FACILITIES BY SEX IN WEST BENGAL

Year	Out-door patients attending Hospitals/Dispensaries		
	Men	Women	Total
1951	33,91,064	20,45,481	54,36,545
1961	57,41,381	43,31,218	1,00,72,599
1971	84,02,742	63,38,910	1,47,41,652



3.3. Social status : Perhaps the single most important reason for the low health status is that they are not valued as much as males.

THIS SEX DISCRIMINATION BEGINS AT BIRTH AND CONTINUES THROUGHOUT A WOMENS LIFE - as is evidenced by the following points.

\* the birth of a female child is not greeted with joy as it the birth of a male child.

\* a female child is not given the same opportunity for education as a male child - as seen by the difference in M/F enrollement in Primary and Secondary schools.

Primary		Secondary	
M	F	M	F
98	65	39	20

This leads to the M/F difference in adult literacy rates, in India as:

Males 46.89%                      Females 24.82%

(Health statistics of India 1985)



In addition culturally, menstruation and child birth, both a natural part of womens life have been associated with impurity and several restrictions have been imposed on menstruating women.

There are several other ways in which women are discriminated

- it is this factor which is responsible for low nutritional status of females throughout their lives as well as the fact that ill health among women is not taken seriously.

#### 4. Some solutions to the problem

- 4.1. As a Programme Manager you should yourself be aware of the problem and recognise that the major cause of ill health in women is the discrimination against them.

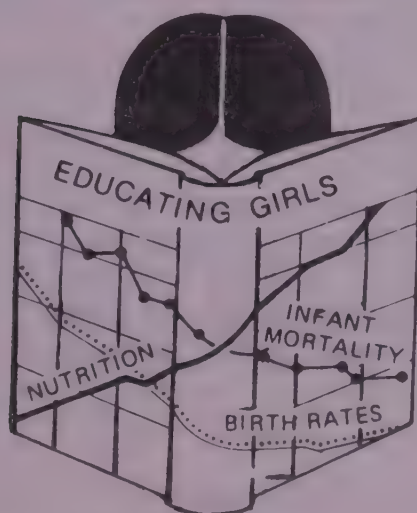
READ ARTICLES IN NEWS PAPERS, WOMEN'S MAGAZINES TO RAISE YOUR OWN AWARENESS OF THIS PROBLEM

#### 4.2. Encouraging Female Literacy

Empowering women through education has enormous potential in raising the level of maternal, infant and child health. Note the relationship between IMR and the education of women as seen in the following chart.

Education of women	Infant Mortality Rate	
	Rural	Urban
Illiterate	145	88
Literate below primary	101	57
Primary and above	71	47

Sources: survey on infant mortality in 1979. Office of the Registrar General.

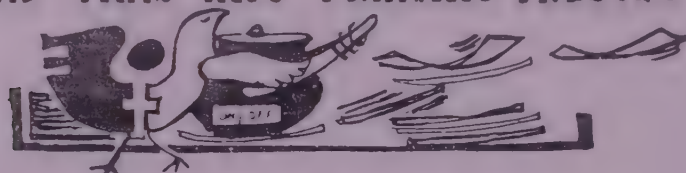


Rising female literacy is closely associated with falling infant mortality

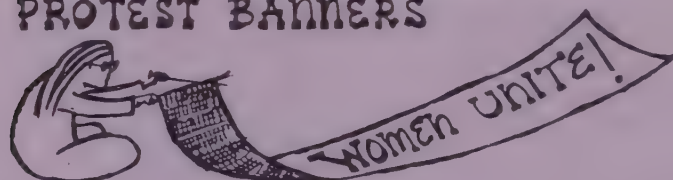
### 4.3 Womens groups

A health programme in Tamil Nadu decided that they should shift their priority from providing MCH services to educating the women in the villages about economic and social issues. Instead of providing services, the women should be organized to demand services from the government. The health worker's main function was to educate women about all the government programmes, meant for the village people but which never reached them. Working in this direction led to the women "flooding the government PCH's to get their children vaccinated". The much surprised health authorities then decided to collaborate with the health programme to provide health services in these villages.

AND THEY SHALL BEAT THEIR POTS  
AND PANS INTO PRINTING PRESSES



AND WEAVE THEIR CLOTH INTO  
PROTEST BANNERS



This experience gave the women confidence in their power as an organized group. The women went further, to take up other issues which affected them. One such issue was that of drinking water. In one village a committee of the women's group had gone several times to the Panchayat Union Office but this effort proved to be a waste of time and money. So they decided to go in large numbers to get their demands for drinking water met-this time carrying their earthenware water pots. But as always the Panchayat Office was not concerned. So the women broke their pots in the office and returned home. This dramatic gesture had its effect. Within two weeks the Panchayat officers came to the village to discuss the problem and before the end of the month, a drinking water pump was installed in the village. The men of the village could not believe their eyes because they had given up the issue long ago as impossible and unrealizable.

## 5. How to impart this knowledge to the CHVs

### 5.1 Points in teaching this lesson

Use the folk tale from Kenya to generate discussion on the role of women.



- \* ask your CHV about their reactions to the stories. Share with them the facts about the low health status of women
- \* make them aware of how society discriminates against women- share facts on male female differences in nutritional status, literacy and social customs which discriminate against women.
- \* share stories like how women in Tamil Nadu obtained services they required from the government.

5.2 Suggested duration of training CHVs: 3 1/2 hours

5.3 Teaching aids:

Collect ahead of time newspapers, magazines, articles, highlighting discrimination among women.

5.4 Assessment:

- questions/answer
- role play on the life of women and change brought about by education and organisation.

6. Summary

- \* The low health status of women in India is largely due to discrimination which begins at birth
- \* Women in India have a much lower status than men.
- \* The problem of discrimination can be overcome by
  - Raising awareness of the problem
  - Increasing female literacy
  - Organising women into action groups

## THE CARE OF WOMEN DURING PREGNANCY

### 1. Signs and symptoms of pregnancy

#### 1.1 Early signs and symptoms ( up to 16 weeks)

- \* Missed menstrual period
- \* Nausea and vomiting - more in the mornings
- \* Frequent urination due to the pressure of the growing womb on the bladder.
- \* Breasts grow bigger.
- \* Nipples darken and may be painful when touched.

#### 1.2 Late signs and symptoms (5 - 9 months)

- \* Enlargement of the abdomen

Normally the womb will be  
2. fingers higher each month.



- \* Parts of the baby can be felt
- \* Painless contraction of the womb
- \* Movements of the baby

### 2. Reasons for ante-natal care - care of pregnant mother up to delivery.

To protect the life and health of the mother and baby

- \* Checking to see if mother is anaemic (Hb below 10 gm %) and to give appropriate treatment.
- \* Provide immunisation against tetanus for the new born baby - 2 doses of 1 ml each, intramuscular 4-8 weeks apart best given in the 6th & 7th months of pregnancy.

- \* To recognise and give early treatment for 'danger signs' in pregnancy.

To ensure the safe delivery of a healthy baby and early recovery of the mother.

- \* Give advice about proper diet during pregnancy
- \* Make sure the baby is growing normally
- \* give advice on how to prepare the home and mother for delivery.

To give advice on child care and family welfare.

- \* Advise the mother about breast feeding especially colostrum
- \* Give mother appropriate advice regarding family planning.
- \* Advise the mother on immunization for children.

### 3. IMPORTANCE OF DIET DURING PREGNANCY:

THE MOST IMPORTANT CAUSE OF DEATH IN THE 0-1 yr AGE GROUP IS LOW BIRTH WEIGHT

The weight of the baby at birth depends largely on the mothers diet during pregnancy.

Mothers from low-socio-economic groups tend to have smaller babies at birth than mothers from higher income groups.



The pregnant woman and the mother breastfeeding her baby, must eat a mixed diet. It means that in every meal there should be cereals, dals or legumes, dark green vegetables, other vegetables with some milk products (if possible). The woman particularly needs foods rich in proteins, vitamins, minerals, especially iron.

Animal proteins are very good but not a must.



- Balanced Diet for Pregnant women (refer chapter on Nutrition).

\* How to make this possible for low income families.

- See tips and low cost nutritious recipes in the chapter on nutrition

#### 4. Detection and advice for "High- Risk" mothers

a) Definition - a "High risk" mother is a pregnant women with any of the following characteristics.

\* Age 17 yrs and below; 35 yrs and above.

\* Having 6 or more children

\* Bad history of past pregnancies.

i.e. Two or more spontaneous abortions

Two or more premature births i.e. born before 9 months, previous ceasarean section, prolonged labour, previous still births

\* Short stature (less than 140 cms in height)

\* Hb less than 10 gms %.

\* Vaginal bleeding during pregnancies.

(b) Why are these mothers considered "High risk"?

Because there is possibly less chance of these mothers delivering a live born child.

So these mothers need more care

\* more frequent checkups

\* a referral to the hospital for more detailed examination

#### 5. Danger signs in Pregnancy:

These are signs which alert you to the possibility of a problem in the pregnancy.

HEADACHE  
SWELLING  
BLEEDING

DURING THE LAST 3 MONTHS  
OF PREGNANCY

If only feet swell, proba-  
bly is not serious. But  
watch out for other signs  
of toxemia. Use little or  
no salt.



If have headache or trouble  
in seeing.

and

If face and hands begin to  
swell - may be suffering  
from TOXEMIA OF PREGNANCY

GET MEDICAL HELP

- BE SURE YOUR FIELD WORKERS KNOW THESE SIGNS SO THAT THEY CAN GET ADVICE AND SPECIFIC TREATMENT FROM HOSPITAL STAFF.
- \* Bleeding from the Vagina
- \* Swelling of the face or feet
- \* Severe, continuous Headache
- \* Persistent vomitting
- \* Pain in the abdomen
- \* Chills or fever
- \* Escape of water from the Vagina

#### 6.1 GUIDELINES FOR TEACHING CHVS

- Training objective: At the end of this session CHVS should understand the reasons for ante-natal care, know how to detect high-risk pregnancies, give the mother appropriate advice during the pregnancy and thus be able to motivate her to accept ante-natal services.

- Content

CHV needs to know: a pregnant mother's need

1. GOOD NUTRITION - as pregnant mother needs to eat for two -herself and her unborn baby.

## 2. HEALTH CHECK-UPS

A pregnant mother should have regular checkups to make sure that everything is normal and to get treatment for any problems.

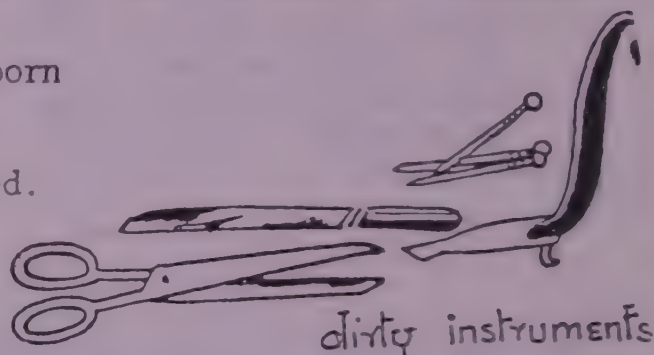
## 3. TETANUS TOXOID INJECTIONS:

To protect the mother and the new born child from the killer disease tetanus (lock jaw)

### TETANUS IN THE NEW BORN

Tetanus toxoid injection is given in the 7th and 8th month of pregnancy

- is caused by cutting the cord of a new born baby with a dirty knife or instrument.
- Both the mother and child can be affected.



# PREVENTION

- TETANUS TOXOID VACCINATION SHOULD BE GIVEN TO PREGNANT MOTHERS

## 4. IRON TABLETS:

To strengthen her blood and prevent her from getting anaemic

- 5. REST - as far as possible she needs to rest for sometime in the afternoon.



Continue to work but get adequate rest and sleep

CHVs Needs to do:

1. Inform the health team of any pregnant mothers.
2. Encourage pregnant mothers to come for check-ups.
3. Explain to pregnant mothers how to keep healthy by eating good food and having regular check-ups.



#### 4. Remind mothers when to come for Tetanus toxoid injection

Duration - 1 day

Training Method: Discussion/mini lecture, visual aids - charts, diagrams

Assessment: Question/answers Roleplay - CHV giving advice to a pregnant mother

Observation and discussion of role play

#### 6.2 POINTS TO REMEMBER IN TEACHING THIS LESSON:

Remember that pregnancy is a very common and "Normal" condition in the village - therefore you may not have to teach the signs and symptoms of pregnancy. You may make a quick assessment by asking the question - how do we know a woman is pregnant

The idea of Regular ante-natal check-up is a NEW CONCEPT IN most rural communities.

Therefore

EMPHASISE THE PURPOSE OF REGULAR CHECK-UPS SO AS TO PROTECT THE LIFE OF THE MOTHER AND THE BABY

- \* A healthy woman gives birth to a healthy baby, a sickly woman has a sickly baby.
- \* A sickly woman is likely to die during her pregnancy and child birth.
- \* A healthy woman and mother, will be able to produce healthy children take care of their health, and the basic education of the children, for which she is primarily responsible.
- \* A healthy woman can help improve the living standard of her family, by engaging in other activities e.g. income generating projects, etc.
- Make sure your CHVS understand the reasons for Antenatal care.
- Initiate a discussion by asking the CHVs to share their own pregnancy experience.
- Then explain the reasons for antenatal care - ask if the CHVs would have liked to have this type of care themselves.
- Encourage CHVs to express any doubts they may have about antenatal care.
- YOU MAY WISH TO HAVE A RESOURCE PERSON WITH MORE technical knowledge to be present at this session.

EMPHASISE: - ALL PREGNANT WOMEN SHOULD RECEIVE TETANUS TOXOID INJECTIONS TO PROTECT THEMSELVES AND THEIR BABIES FROM TETANUS.

SUMMARY:

- ANTENATAL CARE IS IMPORTANT FOR CHILD SURVIVAL
- HIGH - RISK MOTHERS NEED MORE SPECIALISED CARE.
- THE CHV CAN PLAY A KEY ROLE IN EDUCATING MOTHERS AND MOTIVATE THEM TO ANTENATAL CARE.

From 3 month - 7 month  
- once a month

From 7 month - 9 month  
- every two weeks

After 9 months -  
- every week

## CARE OF WOMEN DURING DELIVERY

### 1. Delivery:

Process by which the baby is brought out from the womb

### 2. How to know the approximate date of delivery.

Start with the date when last menstrual period began, subtract 3 months and add 7 days

For example, last period began on May 10, 86 May 10 minus 3 months is February 10. Plus 7 days in February 17, 1987.

The baby is likely to be born around Feb 17, 1987.

REMEMBER THIS IS ONLY AN APPROXIMATE DATE THE CHILD MAY NOT BE BORN ON THE EXACT DATE CALCULATED.

### 3. Preparation for delivery

Remember - BIRTH IS A NATURAL EVENT

When the mother is healthy and has a normal course of pregnancy baby can be born without help from any one.

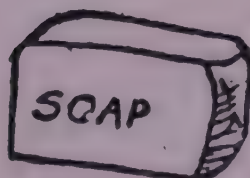
If there is any reason to suspect there will be problems during delivery send the mother to health center or hospital

THINGS THAT MUST BE READY BEFORE DELIVERY:

1. A lot of very clean clothes/rags (washed and dried in Sun)

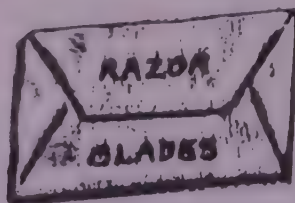


2. Soap for washing hands.





3. A new razor blade to cut the umbilical cord



4. Two ribbons or strips of clean cloth for tying the cord



- SOME OF YOUR CHVS MAY BE TRAINED DAIS WHO WILL HAVE WITH THEM A DAIS KIT.

What is a DAIS KIT?

A Dais kit contains the minimum necessary things that are needed to conduct a clean delivery at home. This can be locally made in a sub centre or in a hospital.

Each kit contains:

One new razor BLADE  
Two pieces of sterile COTTON  
Two strips of THREAD



Mother should be visited by the CHV more often to talk to her and assure her. Mother should be advised to keep her bowels and bladder empty.

In a normal delivery Head of baby comes out first.



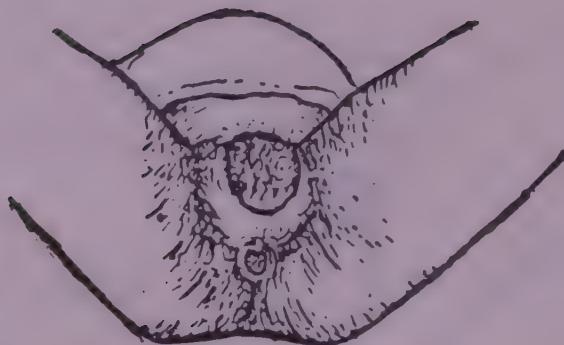
#### Dos and Donts during delivery

##### Dos

- Encourage mother to eat quick energy food during labour like warm milk, with sugar.
- Advise the mother to breathe regularly and relax her entire body during each contraction.
- Rest between contraction - she may sit or walk
- Advise to bear down only when the bearing down pain is felt and bear down only during contractions.

the uterus has led to risk of

- while baby's head is coming out ask mother to breathe slowly.



- After child birth, wait for the placenta to come out by itself.

Never pull on the cord.





- Encourage breast feeding immediately
- "First milk" (colostrum) contains rich substances that increase baby's resistance against germs.



DONT'S

- Do not push the baby downwards



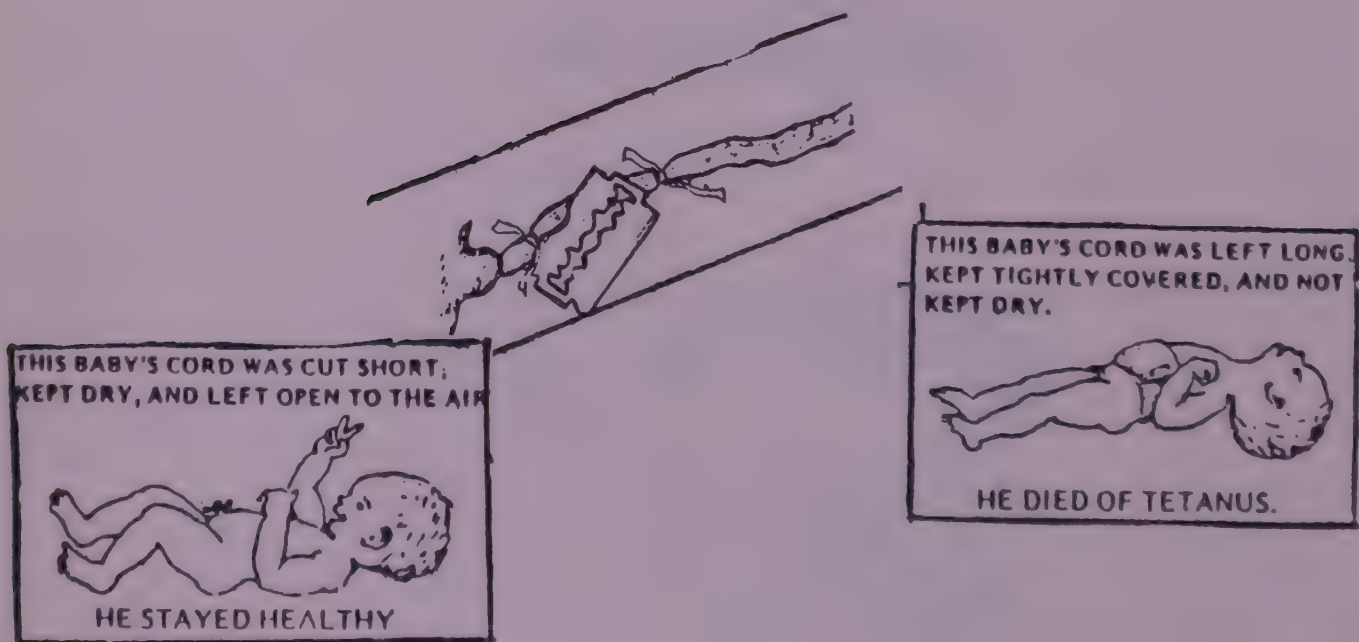
- Do not tie the mothers abdomen



- Do not insert fingers into mothers vagina



- Do not use unclean or rusty knife or scissors or blade to cut umbilical cord. This may kill the baby with tetanus.



- Do not pull on the umbilical cord to bring out the placenta
- Do not apply any dirty material (ash, saliva or cow dung) on the umbilical cord

#### 5. Points for referral:

- Labour lasting for more than 24 hours
- Women with short stature.
- baby's hand or legs are seen on the vagina



- Continuous heavy bleeding from vagina following delivery



- remember this can happen to a mother who has born children 5 times or more and to mothers in whom placenta has not come out fully.
- Severe lower abdominal pain
- fits during labour

#### 6. How to share this knowledge with co-workers.

Your co-workers may be able to conduct delivery at homes. Some of your CHVs may be traditional birth attendants.

CHVs need to know:

- Cleanliness at the time of delivery is very important for both mother and baby.
- The mother should bath and put on clean clothes during delivery.



- Midwife should have clean hands while attending the mother or the baby
- Clean rust free instruments must be used to cut the cord (a new blade will do)
- who are the traditional birth attendants in her village

CHV needs to do:

How to prepare for delivery?

Educate the mother about cleanliness during delivery.

Inform the F.S. about the results of the delivery i.e. live born/still born child male/female, date of birth and the well being of the mother and child following delivery.

#### Teaching materials needed:

##### A. Pictures showing

- (i) Birth of a baby (normal delivery)
- (ii) Cutting of cord
- (iii) Dots during delivery

##### B. Dais kit

#### Suggested teaching methodology:

- Ask CHVs who conduct the deliveries in her village.
- How many mothers/children died during deliveries in the previous year
- In their opinion what was the cause of death
- INITIATE a discussion from this
- EXPLAIN the possible causes of death that had taken place in their villages
- STRESS on the importance of cleanliness during delivery
- ARRANGE - if possible for the CHVs to watch a normal delivery at the hospital

7. Suggested Duration : 2 hours

8. Assessment:

Observation during discussions and question and answers

9. Summary:

It is possible to have a safe, clean delivery in homes. CHVs should know and educate the expectant mothers about preparation for and cleanliness during delivery.

## CARE OF WOMEN AFTER DELIVERY

### 1. Care of mother immediately after delivery:

#### 1.1 Cleanliness

- a daily bath is a must
- wash genital area every day



BE AWARE THAT CULTURALLY IN SOME COMMUNITIES A FULL BATH IS NOT GIVEN TILL SOME DAYS AFTER DELIVERY.

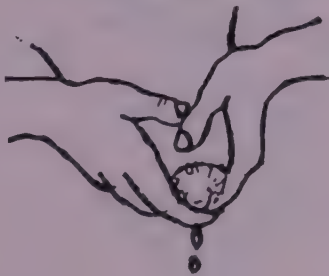
#### 1.2 Breast care

- may need gentle massage towards the nipple to enhance milk flow.
- cleanse nipples with warm water before feeding the baby.

Take hold of the breast  
way back, like this,



then move your hands  
forward, squeezing,



and finally, squeeze the  
milk out of the nipple.



### 1.3 Advice about Diet.

- It is very important that the lactating mother eats a good diet so that she can produce enough milk for her baby (see chapter on nutrition for diet during lactation.)

## 2. Some common problems after child birth.

### 2.1 Fever

- if it lasts more than 2 days is most likely due to an infection.
- this must be treated - consult your hospital for advice on how to handle this problem at village level.

### 2.2 Prolonged vaginal bleeding.

- after child birth vaginal bleeding usually last for 7 - 10 days and has no foul smell.
- bleeding beyond 10 days needs further treatment again you will need to check with your hospital how best to provide this treatment as far as possible at village level.



The woman is losing  
blood through the vagina.

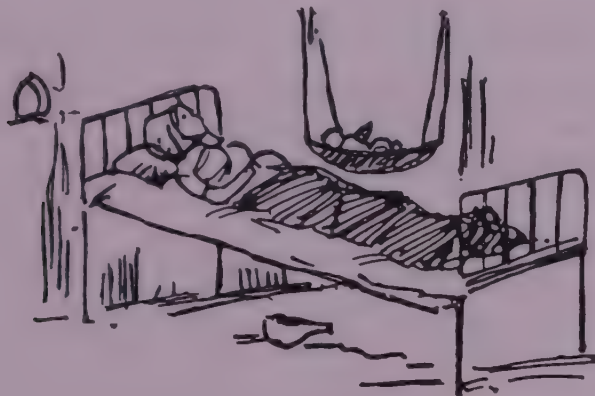
- The field supervisor should visit and give appropriate advice and iron tablets to all women who have prolonged bleeding.



### 2.3 Breast problems:

- Cracked and sore nipples can cause difficulty in breast feeding and thus result in Breast abscess formation.
- Treat cracked and sore nipples with application of a paste made with turmeric and a little oil - between feeds
- Remember to instruct mothers to wash nipples before feeding.
- Reddness and swelling of the breast are early signs of infections in the breast - consult your hospital how best to deal with this problem.

### 3. Care of the New born:



- leave the child close to the mother.
- the umbilical cord should be tied properly and kept dry.
- mother should be encouraged to breast feed the baby at the earliest



REMEMBER THE FIRST MILK (COLOSTRUM) IS RICH IN SUBSTANCES WHICH PROTECT THE CHILD FROM MANY DISEASES.

#### 4. Points for referral

- continuous vaginal BLEEDING
- FITS following delivery
- HIGH FEVER with chills
- foul smelling discharge from vagina
- fresh vaginal bleeding after ten days
- painful engorged breast

Childbirth fever can be very dangerous.  
If the mother does not get well soon, get medical help.

#### 5. How do you share this knowledge with your CHVs

Duration: 1 1/2 hours

Teaching methods

Question and Answers, Discussion

Teaching aid and materials needed:- Flash cards, posters

The CHV NEEDs to know:

- \* personal hygiene of the women is very important following child birth
- \* What some of the problems after child birth are
- \* the diet for lactating mothers (refer chapter on nutrition)
- \* when to visit mothers
- \* importance of feeding colostrum
- \* appropriate family planning methods (refer chapter on family planning methods)

THE CHV NEED TO DO

- visit the postnatal mothers three times during postnatal period
- Identify any problem during the postnatal period and report the following to the field supervisor:
  - name and age of the women
  - sex of the child
  - the person who attended the delivery
  - what instrument was used to cut the cord
  - any material applied on the cord
  - whether baby was given breast feed following birth
- Advise the mother on breast feeding
- Diet during lactation
- Personal hygiene
- Counsel on family planning

#### 6. Assessment:

- questions and answers
- group discussions

#### 7. Summary:

- Women need special care following delivery
- Certain problems can occur during this period

THIS IS THE IDEAL  
TIME FOR GIVING  
INFORMATION ON  
SPACING OF CHILDREN

7

SECTION IV

COMMUNITY BASED ACTIVITIES INCLUDING MANAGEMENT OF ILLNESSES

1. WORKING IN AND WITH THE COMMUNITY
2. GET TO KNOW YOUR COMMUNITY
3. HEALTH EDUCATION
4. MANAGMENT OF MINOR ILLNESS
5. TUBERCULOSIS
6. LEPROSY
7. ENVIRONMENTAL SANITATION





## WORKING IN AND WITH THE COMMUNITY

### 1.1 Definitions:

Consider and discuss the following definitions:

- A community is a social group determined by certain common values and interests, and often (not necessarily) by geographical boundaries.
- A community is a group of people living in a certain area (such as a village) who have common interests and live in a similar way
- In the above definitions, "relationships between members of a community" is generally assumed to be "agreeable and "harmonious"

### 1.2 Why is it necessary to know the structure and function of a community?

- To be effective in a community based primary health programme all members of a health team need to be aware of, and know many aspects of community life such as:

People's customs, beliefs the communities perception of health problems etc.

- Earlier, we seemed to have said that most concepts of 'community' implied that relationships between members in a community are usually 'Harmonious'.

However persons living in the same village (or neighbourhood) do not always

- Share the same interest,
- Have the same degree of power
- Get along "harmoniously" with one another

Even the poor and relatively powerless are often divided among themselves.

In the light of the above, a more appropriate definition may be:

- a community is a group of people living together in a certain area, with BOTH elements of shared interest and harmony, and elements of conflict.

The idea that people will work together simply because they live together is probably a myth. Members of the health team must know this to learn how to take this into account in trying to help the weaker sections of the community.

### 1.3 Structure:

All communities have 'Leaders' and 'social' groups' these are important elements in the 'Power structure' of the community.

Changes can occur only by working within these existing power and influence configurations in a community. Some sources of power and influence are community leaders caste and class.

**Community leaders:**

**Leaders can be classified as:**

- (a) **Formal (official)** . These are individuals who are either employed by the Government, such as BDOs, Tax collectors, school teachers, or elected for state assemblies or parliament.
- (b) **Informal** - These are those who derive their influence (and some power) from the people of the community for qualities of wisdom, competence in certain areas, and altruistic interest in the good of the community.

**Examples:** Religious leaders, Head of an influential household, traditional healers, women leaders, youth leaders.

Both among formal and informal leaders, some have genuine interest and concern for people but some are selfish and corrupt.

Some leaders are  
humble and fair.

Others are  
conceited and corrupt.



It is essential that health workers learn to identify and work with those leaders who share and defend the interests of the poor.

**IT IS ESSENTIAL THAT HEALTH WORKERS LEARN TO IDENTIFY AND WORK WITH SUCH OF THESE LEADERS WHO HAVE AN INTEREST IN SHARING AND DEFENDING THE INTERESTS OF THOSE WHO TEND TO BE NEGLECTED BECAUSE OF POVERTY AND POWERLESSNESS.**

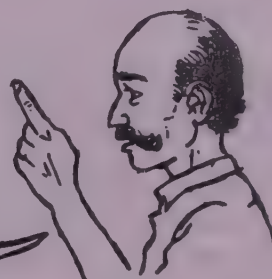


## HOW CAN WE IDENTIFY INFORMAL LEADERS?

A perceptive community health volunteer selected from a community will usually have some idea of the informal leaders. There are some methods that help in identifying them..

- (i) Sociometric method: You may ask several recognised leaders to name three or four persons whom they considered as leaders. The names of those mentioned frequently are taken as leaders.
- (ii) The sampling method: Interview the head of every third, or fifth family as to whom his family would like as a leaders, or consult when there is a problem. The persons whose names are mentioned most frequently are considered leaders.
- (iii) Observation method: Observe which persons in the community are consulted frequently by the people when in need of advice, or who take the leadership roles for festivals, public function etc. A combination of these methods may ensure that various groups in the community are represented.

WORK CLOSELY WITH THE LOCAL LEADERS. TRY TO GET THEIR COOPERATION IN LEADING COMMUNITY PROJECTS AND IN GETTING PEOPLE TO PARTICIPATE.



DON'T FORGET WOMEN.

SUPPORT FROM BOTH TYPES OF LEADERS IS DESIRABLE AS THEY CAN INFLUENCE THEIR RESPECTIVE SUBGROUPS, TO HELP IN THE PROCESS OF ACHIEVING THE DESIRED CHANGES.

Caste:

The caste system is probably unique in India. It has a fairly big role to play in the dynamics of community life. The higher castes are also generally the richer people, and the combination of caste status and money power makes them a "power-group" to contend with.

IT IS IMPORTANT TO REMEMBER THAT NO LEADER IS ALL GOOD OR ALL BAD. THE CHALLENGE FACING MEMBERS OF THE HEALTH TEAM IS TO BRING OUT THE BEST IN ANY LEADER WE HAVE TO WORK WITH.

YOU CANNOT IGNORE LEADERS. IF YOU WANT CHANGES IN THE COMMUNITY.

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POINTS TO IDENTIFY LEADERS WHO ARE LIKELY TO BE SUPPORTIVE RATHER THAN SUPPRESSIVE OF COMMUNITY'S GROWTH.

- \* How was the leader chosen, and by whom?
- \* Does the leader represent the interests of everyone in the community.
- \* Will this leader's decisions, and advice affect people's health?
- \* Is he impartial? give examples to corroborate your answers.

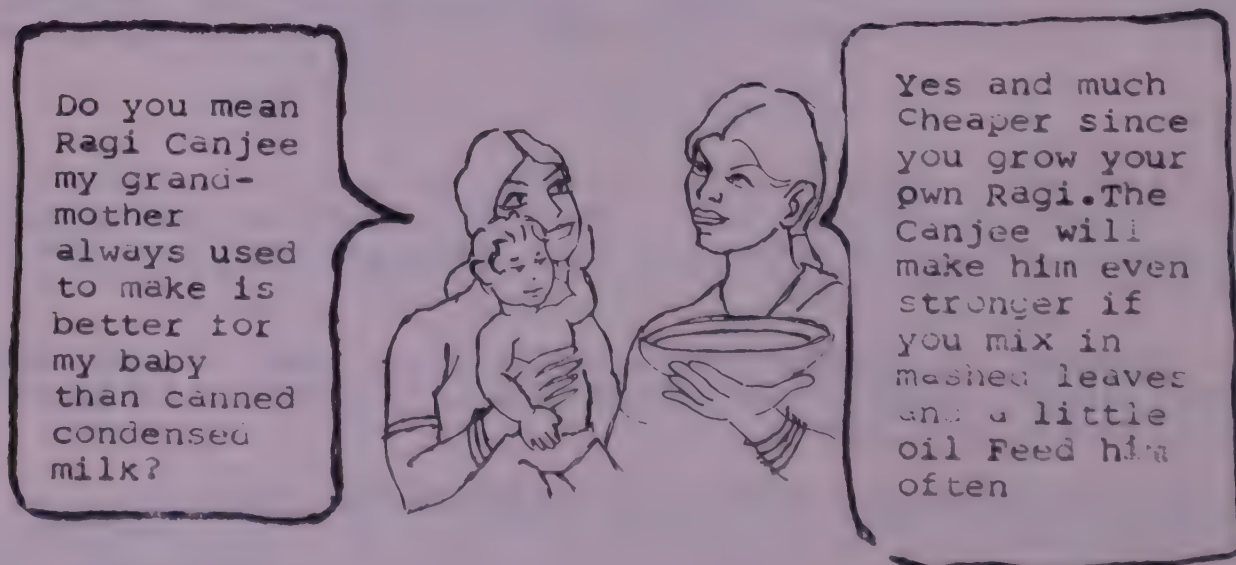
#### 1.4 VALUES, CUSTOMS, BELIEFS

All communities, in course of time develop a set of customs, and belief pattern, which become well established and entrenched. The more traditional society the more established these are.

We should examine our tradition critically, and preserve those elements which are good... and have stood the test of time... we should not hesitate to modify or even throw away those elements which maybe... obsolete or harmful

It may be worthwhile looking at some examples of values and customs, that have a relationship to health and the health delivery system.

- i) A valuable aspect of our tradition is its non-consumerist approach to life, value and pride in simplicity of life with no undue desire to possess and accumulate things. This is in total contrast to the 'consumerist' life-style of the industrial West. A return to our tradition with some adaptations, is a safer road to health for India. (Is Gandhi relevant today)
- ii) Our tradition places strong emphasis on simple but effective things such as naturopathy, yoga, use of herbs. Recent critical research is establishing the scientific evidence of these. Promote them.





## Customs and traditions

- There is a need to take seriously the concept that there are beneficial customs and traditions.
- Health professions in general have been guilty of the following:
  - a) "Looking down" with scorn on local beliefs and traditional forms of health as old fashioned, unscientific and worthless.
  - b) Failing to take interest and look at local traditions and customs that are related to health, and evaluating them as to their value and effectiveness etc.

"Looking down" with scorn is the worst kind of approach.

Many health problems in communities today are the result of people abandoning old customs for new ones, taking to new 'styles of life' without critically analysing the 'Pros' and 'cons' of the old and the new, and often through the pressure of powerful advertising and propaganda for use of new device.

### Examples:

1. Breast feeding has been overtaken by bottle feeding, the latter being largely due to promotion by international companies. There is ample evidence to show that.



2. The general pattern of young wife's going to their own mothers house for delivery and staying on away from the husband, resulting in a form of abstinence and aided by the belief that sexual union when the child is on the breast is taboo for various reasons has helped spacing of births.

The breakdown of this pattern due to various sociological factors, has created some problems such as lesser spacing of birth, and more unwanted pregnancies, increasing abortion, and so on.



## The Cultural interface between subcultures

It is important to realise that the members of the health team, (except for the CHV who is of the community itself) by virtue of their education and some acquired attitudes and life-styles, have become an educated elitistic subculture, and are therefore outsiders, to the village community. There is thus a subtle cross-cultural interface, which needs to be recognised, and dealt with by the health professional.



### SUMMARY

HEALTH PROFESSIONALS CONCERNED WITH PROMOTING HEALTH NEED TO BE AWARE OF THE IMPORTANCE OF RESPECTING LOCAL TRADITIONS, HELPING PEOPLE TO SORT OUT THE BENEFICIAL FROM THE HARMFUL, AND PROMOTING DESIRED CHANGE WITH AND BY THE COMMUNITY



## 2. COMMUNITY ORGANISATION

### 2.1 All communities are organised:

In predominantly agrarian communities, organisation was simple. The foci of power, or decision making was limited to few people.

- Experiments in organising small communities where people relate harmoniously to each other and to nature, and are largely self-sufficient and self-reliant in food, clothing and basic educational and health facilities have been tried in various countries, with varying degrees of success. Gandhi's experiments in Sevagram, the ashram movements, 'communes' in China and elsewhere are examples.
- Such groups do demonstrate effective democratic organisation but are difficult to replicate.

## 2.2. The Gram Panchayat and the Panchayat Samiti

As Project Manager you should be familiar with the patterns of community organisation existing now.

Essentially it is an establishment of a Panchayat Raj system with a three tier structure of local self-Government at village, Block, and district levels, with all three levels being bound together, and members are elected, and there is a special representation of various bodies, such as the women's groups, cooperative societies etc. The Panchayat Samiti, (i.e. the union of panchayat, of a community development block is responsible for agriculture, rural industries, health including medical relief and maternity and child welfare, village roads, tanks, and wells and maintenance of sanitation.

The Panchayat, and the schools are the basic village institutions for carrying out democratic de-centralisation.

The elected panchayat is responsible for overall development. The cooperatives for economic development. The village school is often the community centre for educational, cultural and recreational activities. There has been a steady increase in the organisation of Mahila Mandals and Balwadies. Special programmes for improving the quality of life are also grafted on to the Block-Development activities as for example the composite programme for women and children, stressing nutrition and education for women, the Integrated Child Development service Schemes (ICDS) etc.





The Health care of the rural community rests, at its most peripheral level with the Primary Health Care (PHC) which is considered the health wing of the community Development Block, but it is administratively under the Health Department of the state. For our purposes the PM should be aware that this system has evolved to the stage of having the following staff for a population of 5,000 to 8,000.

While the quality of implementation of the various/programmes may be poor, it is foolish not to try and utilise these resources in the projects run by voluntary agencies.

Do we have to organise the community?

While every effort should be made to try and work through the existing community organisations, there is the likelihood that they are dormant, and also controlled by the rich who are powerful because of their riches, or their higher 'caste' or social status. Since most of the problems in health are closely associated with poverty and ignorance and the poor are powerless and helpless, it may be necessary and desirable to organise something different, to ensure that those who need help are not neglected. Organising the community is also necessary to encourage participation and cooperation from the people. This is discussed further in the next section.

### 3. Community participation

#### 3.1 Why is participation important:

- a) Because we are involved in the community based Primary Health Care Programme with special attention on Child Survival, we want to move away from an inappropriate imported model of health services with minimal or no participation from the the community to a model where Community participation becomes very important.
- b) In the past, the average citizen was considered to be the "Object" of health care, and the responsibility of defining and meeting his health needs was considered to be with the health professionals, mainly the doctors, including public health officers. Now, the citizen is looked upon as the 'subject' rather than the 'Object' of health. In the new approach health is considered to be a process where the people are enabled to understand the multiple causes that contribute to 'being healthy' or ill, and strive to solve them with minimal dependency on others. In this process of assuring the survival of children, it is increasingly realised that the 'health technology' that is available to help the survival of children, can be transferred effectively only through informed participation of the community and the mothers and fathers (the parents) in particular. A process of Democratic decentralisation in real terms is necessary, and it has to be a programme of the people by the people and for the people.

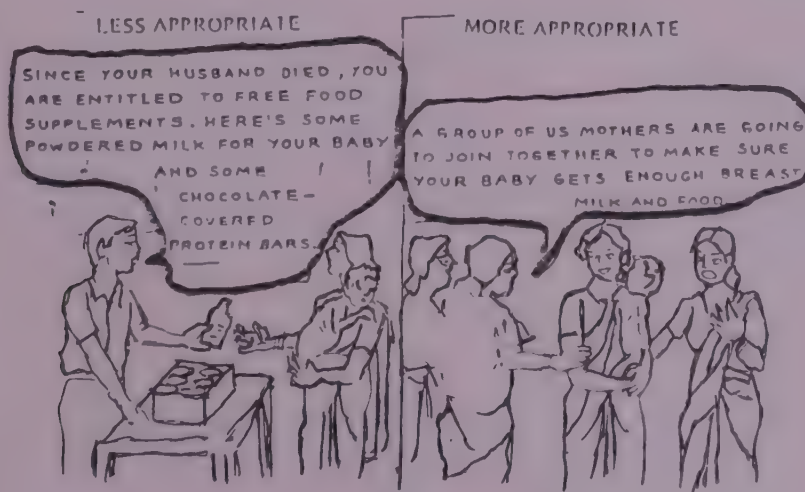


Participation  
as a way for  
people to gain control



### 3.2. What is community participation?

"Community Participation is a process by which individuals and families assure responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and their community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid... They have to acquire the capacity to appraise a situation, weigh the various possibilities and estimate what their own contribution can be. While the community must be willing to learn, the health system is responsible for explaining advising and providing clear information about the favourable and adverse consequences of the interventions being proposed as well as their relative costs" (Source primary health care, Joint report of the WHO & UNICEF- 78).



The implications of the above concept of community participation are :

- 1) Implementing the principle of democratic decentralisation.
- 11) Helping the people to acquire the capacity to apprise a situation, possibly with the help of the professional staff that may be available. In the context of the object of assuring the survival of children to the age of 2 yrs : the preliminary survey to get a profile of the community with special reference to the number of children who are at risk of falling ill or dying, the participatory process of finding the possible ways of mitigating the situation; and be the function of the health professional to facilitate the process ensuring that the community makes the important decisions on the basis of the 'clear' information about the favourable and adverse consequences of the interventions being proposed.

### 3.3. Patterns of participation

There are two basically different kinds of participation:

- (1) Participation as a way to facilitate and improve the delivery or implementation of a set of predetermined activities designed to achieve the objectives of a programme which may not have been formulated with and by the community. Here the goal of participation is to influence people and persuade them to participate in implementing a programme which has been identified as meeting the felt needs of the community, and for which the technology is being provided.
- (2) Another view of participation is that it is a process in which the fact of inequalities in a community is squarely faced, and the community participates in understanding the situation, and takes steps to change aspects of the community structure and function to meet the communities needs, be they health or socio-economic etc.



## Patterns of participation.

There are two different kinds of participation. The salient differences are given in the following table.

----- Participation Model I -----	----- Participation Model II -----
1. Assumes that a community is homogeneous; any inequalities are not taken seriously.	1. Accepts the reality that most communities are not homogeneous and is concerned about various disparities.
2. Identification of Needs:  A small group of individuals (External or internal) Identifies needs (Felt or real with cursory discussions with community.	2. Identification of Needs: is done by the people on a democratic basis.
3. Programme planning & Implementation.  (a) The same small group, plans and implements a programme to meet the identified needs of problems.  (b) Believes that persuasion of people to implement pre-determined programmes is community participation. Decision making is mostly by the small group.	3. Programme planing & Imp- mentation.  Believes that programme planning and implementation should be by the people for the people, with minimal facilitation by the technical advisors only if invited by the community. Decision making is by community through the democratic process.
4. Believes that technological interventions for the good of the community need only Community's cooperation and this is accepted as community participation.	4. Believes that a community has to accept the technological interventions as being beneficial through and process of corporate decision making, only then is it community participation.

It is necessary to notice that Model I, does not take the fact of inequalities seriously, and that the marginalised and poorer sections of the community are likely to be neglected. It is therefore helpful for the community organisers to consider the following carefully.

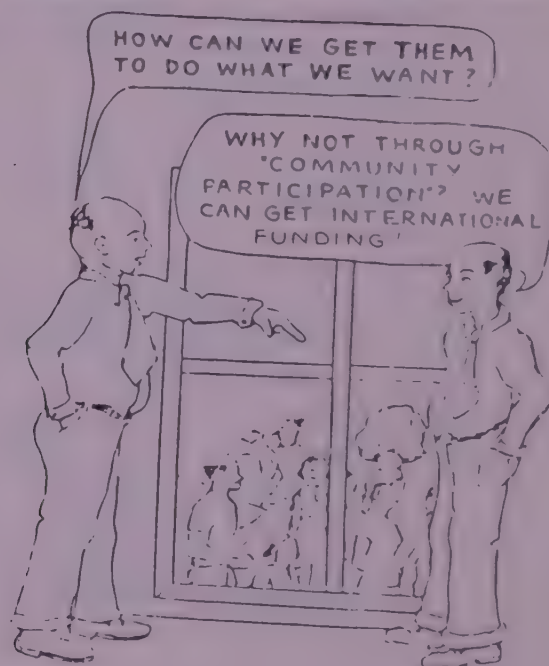


- \* Whether to promote - effective participation within the already existing community groups;
- \* How are the community representatives chosen?
- \* Do a good proportion of them represent the underprivileged? Or is it dominated by the rich and powerful?
- \* What are the links of the majority of the participants to those in positions of power or authority?

For example: If the existing organisation is biased in favour of the privileged, it may be necessary to form a new community forum that is more likely to involve the poor. This will empower them to participate in promoting a programme which ensures that the desired benefits will reach the target group.

Each one of these approaches have their merits and demerits. This requires that the community organisers have to consider the following carefully.

Participation  
as a way  
to control people



### 3.4 Importance of organising women

In the chapter on Women and Health you will find excellent evidence to show that women are heavily discriminated against. In relation to the project of the CMAI, the emphasis is on women and children for intelligent participations in improving their position in society and more important that they can participate in promoting their health and ensure survival of their children.

This approach is not designed to disregard the men, and men's groups. But it is only through a process of 'Empowerment' of women, by helping them appropriately their rightful share of resources and privileges, thus gaining a sense of solidarity to stand up to the insensitiveness of men in a male chauvanistic culture, can effective changes be brought about. Womens groups have brought about more changes in many spheres than men's groups.

You may find that there are already existing Mahila Mandals in your area. It will be very fortunate if they are active and dynamic. If they are not, you will need to take steps to revive it, if necessary restructure its composition etc, doing all that with great care, without hurting or creating conflicts etc. Organising and working in and through the Mahila Mandals keeping in mind the general principles mentioned will be most important for the project you and your colleagues are involved in.



### 3.5 Youth and Young Farmers groups

An important section of the population in village communities are the young people, especially the young farmers, who are helping the parents. However many of those are likely to belong to the richer landlord families, and they may not be the ideal group to bring about changes that are to help the poorer communities. Even so they are likely be young husband who need exposure to the population problem and be introduced to the small family norm.

The great value in keeping in touch with the young is that the innovators in the community are likely to be found among this group, be they male or female. It is important to be in good rapport with this group, as they can be roped in to participate in mass campaigns, (pulse immunizations for example). There are examples of using the forum of young farmers clubs who are given various inputs of training and incentives for taking up new farming methods for improvement in food production, for education and subsequent participation in family planning programmes, and being motivated to participate in nutrition programmes; a group of young farmers leased out the village tanks to be involved in fish farming and in the distribution and marketing of the same, and making it available at subsidised rates for dealing with protein calorie deficient children in the community.



The incorporation of the younger leaders of the right kind in the Advisory Committee can be of great help.

### 3.6 Conditions necessary for successful community participation.

- i) Members of the Committee should be selected, by using procedures such as given in the section on leadership. Care in the selection of the right kind of people is crucial.
- ii) The frequency and timings of the meetings must be convenient to most of the people, (not the convenience of the staff). This is specially true for the women's meetings.
- iii) As far as possible use the already existing community groups; in case it is noticed that these are inactive, or the composition is heavily loaded in favour of the privileged, be quick enough to organise a new committee in consultation with the community.
- iv) Knowledge and use of principles of 'group dynamics' such as :
  - (a) sitting in a circle.
  - (b) encouraging others to take the lead and to speak,
  - (c) tactful handling of the dominating talkative person,
  - (d) help the relatively quiet and silent ones to give their opinion,
  - (e) strive to keep the atmosphere one where every one feels free to speak, esteemed, respected.

### SUMMARY

The discovery that one of the major reasons for the dismally slow progress in the improvement of the health of large sections of our population is that the citizen was the 'object' of health care, and the new approach is in considering him as the 'Subject'. This important change is evident in the concept of primary health care approach as enunciated, and the realisation that the individual's as well as the community's health can be promoted and safeguarded only with the help and active participation of the community. The essential aspects of community participation and how this can be exploited to achieve the goal of child survival, and the promotion of health is discussed. This outline should provoke the health team of the programme to utilise the strategy of community participation.

## 4. COMMUNITY DEVELOPMENT

### 4.1 Various concepts or approaches to development

1. "Community Development is a process designed to create conditions of economic and social progress for the whole community, with its active participation and the fullest possible reliance upon the community's initiative". (Bharkat Narain, Swasthi Hind 1961).



2. "Community Development is a process by which the efforts of the people themselves are united with those of Government authorities to improve the economic social and cultural conditions of communities to integrate those communities with the life of the nation and to enable them to contribute fully to national progress". (Park's Text Book of Preventive and Social Medicine).
3. "Community Development is a process that enables the development of a self-reliant, self-sustaining and participating society with equality of opportunities for all, and social justice." (Hulbe 1980- Approaches to Rural Development, Paper presented in 1980 and published in Integrated Rural Development by NCC of India).
4. "Community Development is the process by which there occurs a development of human beings as a community aware of its rights and potential and capable of changing itself" (Adapted).
5. "Development is a process whereby the people, the poor and the oppressed being the primary bearers of humanization, liberate themselves from all forms of enslavement and create a condition in which there are no oppressors and oppressed. This frees persons, communities and nations to realise their full potential as every individual has access to health wealth, power, respect, knowledge and well being.

"Thus development, in the final analysis is people transforming the world and creating their own future; thus it is participating in God's redemptive plan for mankind" (Adapted from a church statement on development by the N.C.C. in the Philippines in Guidelines for Development: CCA, 1980).

The above set of various definitions have been given solely with the purpose of stimulating thought and reflection which should precede action; it is meant to help the Health Team of the CMAI internalise for themselves their role in the programme.

It is also necessary to understand the evolution of the approaches to Development.

- Considering people as the subject of change and development;
- Acknowledge that development should lead to liberation from all forms of enslavement and bondages (including illness).

From Charity and Social Welfare to the Development approach

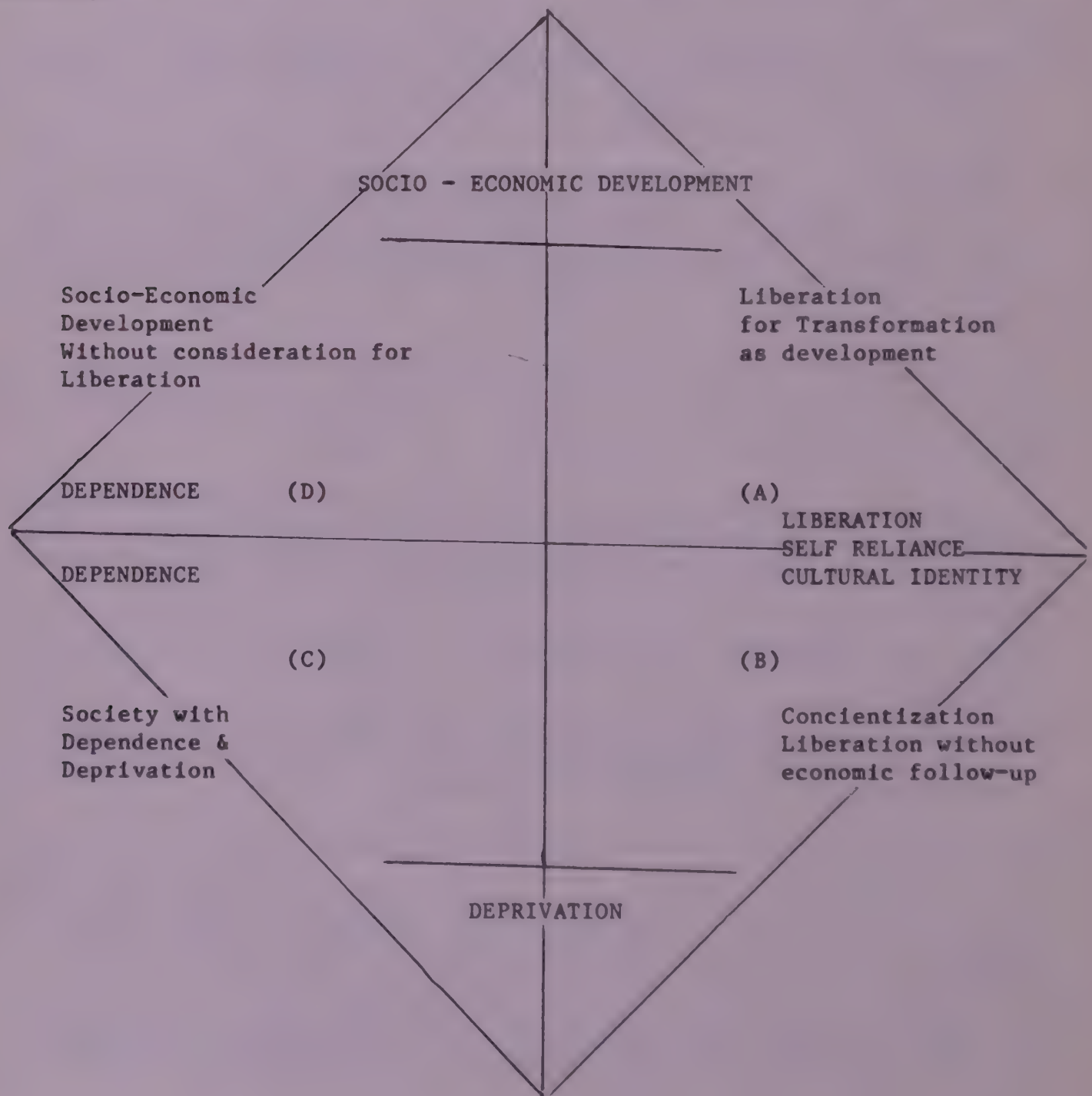
This is another part of the evolution of ideas and approaches. This kind of approach is confined to situations of calamities or other crises. It is temporary, and confined to the particular people effected. This is not development.

The Reform Approach. Here the main aim is to help the prevailing socio-economic and political system to work better- aid employment, and improve health, education etc, (See (1) above).

The Transformation approach. This approach takes the view that the problems and the society can be traced to the marginalisation of certain sections of the populations by strategies which preserve the concentration of privilege and power with a few.

The need is to work with the poor and marginalised, help them to understand the root causes behind a situation, and encourage self-help and concerted action. this approach invariably involves tension and conflict, but sees tension as having the potential to be creative. There are variations in this approach which has Transformation as the key word.

The following diagram is an attempt to express the varieties of approach graphically.





The vertical axis deals with the means of development. The horizontal axis stresses the objectives and deeper values of development.

Quadrant (C) links deprivation and dependence and declares the state of the poor and oppressed.

Quadrant (D) indicates where most traditional development efforts are. It engages in economic improvement activities without altering the dependency of the people and often deepening it, and leaving them exposed to continuing exploitation.

Quadrant (B) is an area, where as a result of conscientization people are politically conscious, but do not have the means to rise out of poverty.

Quadrant (A) declares a direction for development efforts. There is awakening, education, organisation and action for power, some economic activity, enabling people to become artisans of their own destiny.

WHERE DO WE THE CMAI TEAM FIT IN?

#### 4.2 Evolution concept of Social - Economic development

Without disregarding all the various concepts of community development referred to, it is suggested that for the practical purposes it is useful to give more attention to social economic development. Some of the reason for choosing this model are :

- a) POVERTY is considered as the most important social evil in the configuration of the multiplicity of causes of disease.
- b) IGNORANCE including wrong beliefs and harmful traditional practices, is the other important factor in the causation of many diseases, and more so in the prevention of disease. Without going into the issue of whether to tackle the causes of poverty, (by evolution or revolution), most programmes aim at -
  - i) mitigating poverty, through income generation schemes, self-employment schemes etc.
  - ii) dispelling ignorance through the educational processes.

A mid-term review three decades after our country dedicated itself to create a new social order based on equality, freedom, justice and dignity of the individual and to eliminate poverty, ignorance and ill health found that as far as health is concerned, the country is still far short of its objectives. It also found that "an attempt to eradicate ill-health will not succeed in isolation, and that it can be pursued side-by-side with the other two interdependent and mutually supportive objectives of eliminating poverty, inequality and ignorance, and against the back-drop of a socio-economic transformation..."



"The attainment of this goal depends, above all, on three things : (I) the extent to which it is possible to reduce poverty and inequality and to spread education.." (Ref ICSSR & ICMR publication Health for All, parts of 14.23 and 14.24, page 224).

4.3 Government's approach - through the Community Development Process has already been mentioned in the section on Community Organisation. The Programme Manager can get all the relevant information from the Block Development Officer/Panchayat Union Commissioner. A special effort should be made to help people in the community to demand and get the benefits of the various schemes which are aimed at improving the per capital income. Cutting the Red-tape in the bureaucracy will go a long way in helping the people and this in turn will improve the credibility of the health professional as well as the programme.

WE ARE CAUGHT UP IN A POVERTY-IGNORANCE TRAP. AMONG THE VARIOUS APPROACHES AVAILABLE COMMUNITY DEVELOPMENT IS ONE. HEALTH PROMOTERS CANNOT DISREGARD DEALING WITH THIS `TRAP`.

## 5. Community Diagnosis

Ideally, a community diagnosis is a self analysis by a community of the problems that concern them most. More attempts should be made to have this kind of community diagnosis.

However, when there are programmes with definite goals and objectives, it is necessary to have a `profile` of the community, to enable a `diagnosis` and to plan the `therapy`. Data have to be collected and this process is through a survey. More details of this are given in the chapter on letting to know your community.

As a guide to the community diagnosis the kind of information that is helpful can be classified as :

### 1) NEEDS

- \* Local health problems and their causes;
- \* Other problems that affect people's well-being;
- \* What people feel to be their biggest problems and needs;

### ii) SOCIAL FACTORS

- \* beliefs, customs and habits that affect health;
- \* family and social structures;
- \* traditonal forms of healing and problem solving;
- \* way people in the community relate to each other;
- \* ways people learn, especially other than traditional ones;
- \* who controls whom and what (distribution of land, resources and power);

### iii) RESOURCES

- \* people with special skills; leaders, healers, story tellers; artists, craftsmen, teachers;
- \* organised health services - what kind and by whom
- \* land, crop rotations, water, fuel, live-stock etc.
- \* markets, transportation, communication;
- \* availability of work, earnings in relation to cost of living

Ideally, these facts however gathered, should be shared with the community, and the health professionals and the community members together should try to find answers to questions such as the following:

- \* How do the combined facts of the situation, i.e. needs, social factors and resources affect our well-being; of women. children under five etc?
- \* How can we go about improving the situation?

A COMMUNITY ANALYSIS (DIAGNOSIS) IS HELPFUL AND NECESSARY. IF THE FINDINGS CAN BE SHARED IN A MEANINGFUL AND APPROPRIATE WAY WITH THE COMMUNITY (OR SECTIONS OF THE COMMUNITY)? WE CAN HELP PEOPLE MEET THEIR OWN AND EACH OTHERS HEALTH NEEDS MORE EFFECTIVELY.

### 6. Guidelines for teaching the CHV

CHV should know :

- the value of her own knowledge of her community, and the ways of defining the same by methods of identifying leaders, analysing the role of power and influence sources.
- how to help the health team in making a community diagnosis.

CHV should do:

- identify more leaders
- help the poor and powerless and marginalised
- help the team in the formation of committees, and groups, especially the Mahila Mandals
- help assist the health team in any socio-economic development programmes, if any.

Duration: 14 hours

Content:

Elementary principles of building up on her existing knowledge of her own community.

Refining on and enlarging the list of opinion leaders.

Some insight into group meetings and how to conduct group meetings.

Explaining the why and the how of community diagnosis.

**Methodology:**

Mini lectures and group discussions. Demonstrate the ways of conducting meetings well.

**Assessment:**

Through observation of her organising and conducting meetings in the class room or village situation, the latter being more preferable.



## GET TO KNOW YOUR COMMUNITY

### 1. RAPPORT BUILDING:

#### 1.1 Purpose:

- To work with people you have to begin by establishing a good relationship. You have to get to know the village men and women and they need to know you and the project.
- Building rapport is necessary because as fieldworkers you will have to communicate continuously with the villagers and gain their confidence and acceptance.

Building rapport takes time and work. It does not happen in one meeting with a villager. But it is very essential that you attempt to relate with villagers in a friendly trustful manner. Without this you cannot really work effectively with rural people.

#### 1.2 How to enter a village?



### 1. Contact and talk with the community leaders

- e.g. Village panchayat secretary  
Teachers  
Retired army officers  
Field-workers  
Elders  
Some of the progressive farmers  
Pandits  
Leaders of women's organisations  
Traditional healers and birth attendants.  
Men group organizers  
Women group organizers  
Other influential people  
(write down their names for future use)

2. Begin by introducing yourself,

- who you are, and where you come from
- the project you are associated with, what benefits it can bring to people
- how community people can work with you (fieldworker) to obtain advantages from the project.

Note: when explaining the project to village leaders and officials you need to include other kinds of information and details e.g. the organisation and institution you are working for. Keep your explanation very simple.

3. Get the agreement and co-operation of leaders to work in their villages, and with various house hold and family members. This is a way of legitimizing your official role, and gaining acceptance in the community.
4. Request the village panchayat secretary and other community leaders and CHV to take you around the project area, and introduce you to other villagers.

ONLY COLLECT INFORMATION  
RELATING TO  
YOUR OBJECTIVES

5. Walk around, go to peoples' homes, make information contacts with other people in the community who are not leaders.

e.g.

- small farmers
- shop keepers
- women
- health workers
- other extension workers in agriculture family planning
- elders
- youth groups
- persons from different ethnic groups
- etc.,

Try to talk to as many people as possible individually or in small groups, about the project and your role.

6. At the end of the day you can prepare a brief note of the people and households you contacted, who were most interested in your project.

(This list will be useful to you when doing the needs assessment exercise, and in identifying community people interested in working with you)

7. Generally expectations are very high with your arrival in the village. Check again with the villagers to see if they have really understand your programme. This is the stage when misunderstandings can arise, about you, and about the programme. Clarify these immediately, so that people have a realistic picture through your project and what it is not.

- \* Introduce yourself in a cordial, friendly and humble manner
- \* Do "Namaste"
- \* Speak in the dialect of the villager if you can.
- \* Address him/her as, (local terms for mother, sister, brother etc.) as the local custom suggests.

Do not use personal names.

- \* Be personal in your approach, ie. talk to people about their families and household matters, - things of most interest to them. Women like to be asked about their children and their household responsibilities.
- \* Be brief and clear when explaining the project and your role.
- \* Let villagers speak out even though it may be unrelated to your project. Try to ask what they are doing?
- \* Listen attentively and sympathetically to their views. A monologue does not go very far.
- \* Sit on the floor with the villagers, or on the bench with them. Do not sit on a chair, while the villagers sit on the floor.



- \* If offered chaya or something to eat and drink, try and accept it (unless you have a health problem) or else people will be offended.
- \* Villagers may ask you personal questions. 'Are you married'?

What do you earn, etc.. They are curious. Be polite in your answers, you do not need to give a lot of details, but do not be indifferent. Sometimes a humorous response or a joke about yourself is the best way to deflect curiosity without seeming unfriendly.

## 2. How to become familiar with the project area and prepare a simple community profile:

### \* Purpose

- \* Besides getting to know the people, you need to have an understanding of the kind of project area you are working in - e.g. how many people live there, what they do, by profession and in their free time,

### 2.1 What are the resources, what is the social and economic situation of the area, some of the ongoing activities in the area.

- \* This information gives a clear factual picture of the area, and will provide you with the background required for the needs assessment exercise that you will later carry out.
- \* It will be very useful if and when you start to plan specific income generation and community development projects.
- \* It will also be useful when outside consultants at your request, come to help you in doing feasibility studies for more complex project

### 2.2 KINDS OF INFORMATION NEEDED:

- Names of panchayats
- Geographical location of the area you are working in
- Socio-cultural features:
- Population, the number of households, ethnic groups, location of houses and facilities, whether or not ethnic or caste groups live clustered together, languages spoken, religious practices, and the literacy level.

Economic factors e.g.

- \* Main sources of the economy, main occupation of people part time jobs offered or available, existence of markets, natural resources present land, forests, rivers, roads and trails.
- \* On going development programmes in the project area.
- \* Services that are available. i.e. hospitals, Primary Health centre, water supply, schools, co-operative centres etc.

## Sources of information:

You can collect this information from various sources:

1. Your own visit around the project area.
2. Villagers, village panchayat offices, community leaders and co-workers.
  - women's organizations
  - extension workers
  - banks
  - other organizations in the area
  - P.H.Cs
  - technical workers from outside the area
3. Reports or surveys already prepared in the area by the district office, or other government agencies.
4. Information available from your institution

If you find that a community profile of the area has already been prepared, get a copy for your use. Study it carefully and add other facts that will be useful to you. If you need to prepare one, here are some suggestions.

### 2.3 Suggestion for preparing a simple community profile

\* make it short and simple

\* the information should be useful to you and others who will use it. It is not an academic exercise. The community profile should be prepared by the team. It can be done within the first or second month of your work and you can add more details to it as you go along. You can put it together as shown as an annexure.

The community profile gives you some basic facts and figures, about the project area, and a general idea about the villagers living conditions. Now you need to gather information which gives you a deeper understanding of the real situation of the people in the area, their strengths, needs- the things they lack in order to have better lives, their main problem and their interest. If you go to a village and ask people what are your needs at first they may not quite understand what you mean. So give an example, ask them what are some of the most important problems they face in their daily lives. They may then indicate a wide range of needs for entire population of the area. For e.g. many individuals/families may say that their problems is getting water. This could also be a need felt by the general community- lack of drinking water facilities.



### 3. TOOLS & SKILLS TO ASSESS COMMUNITY NEEDS

Purpose & importance of assessing needs: to learn about:

- 
- |   |  |
|---|--|
| 1. Identify problems/<br>needs  | * the main problems/needs and interest<br>of people<br><br>- special needs and problems of women<br>and children<br><br>- the causes of these problems.  |
| 2. Suggest solutions<br>to problems   | - what people would like to do to change<br>their situation, e.g. take up economic<br>community development activities.  |
| 3. Define relevant project<br>in the community and<br>encourage participation | - Assessing needs properly is a key step<br>in getting people to identify the<br>projects/activities that they think are<br>important in solving some of their<br>problems. Villagers are more likely to<br>participate later in projects that<br>follow. Projects as a result of this<br>will be more successful. |
| 4. Assess changes and improve-<br>ments at a later stage.                     | - Assessing the needs and problems in the<br>early stages of your work, helps you to<br>record the situation in the community<br>and individual household. At a later<br>stage you can make comparison to see<br>what changes have occurred and the<br>benefits realized by people.                                |
- 

There are no set rules, or one right approach for assessing needs. We are making suggestions based on the experience of field workers who have done 'needs assessment' in the rural area.

#### 3.1 OBSERVATION OF THE COMMUNITY:

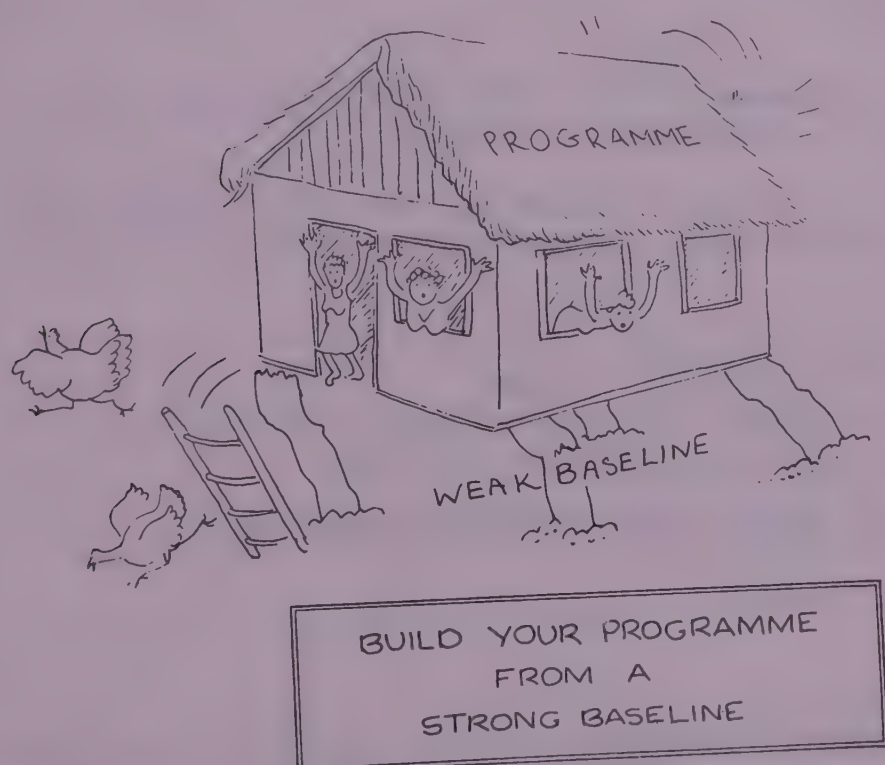
From the time you start work in the community you need to observe people and their surroundings. You should add this when preparing a community profile, when carrying out a survey, or in talking with people informally.

You can find out as much by watching the way people behave and do things as you can by asking questions.



\* Train your eye to see as much as possible, (not just the things you are looking for) e.g. when you arrive at the home of the person you are going to interview:-

- look at the surroundings - are they clean, well kept?
- does the household look fairly well off or poor, do people look happy?
- appearance of children, are they clean, healthy, going to school?
- is there a vegetable garden, fruit trees etc.?
- write down as much as possible (do not rely only on memory)
- do not rely on one time of the day for your observations to be accurate, visit again at different times.
- check observations with oral questions.
- check your observations with other people's observations, either with your team members.



### 3.2 Survey with villagers:

What it is ?

A survey is commonly used to help us in interviewing people and collecting information about their needs/problems. It consists of a list of questions or points with a specific focus about which detailed information is required.

Different agencies and organizations have designed specific surveys depending on the kinds of programmes they are supporting. You will be required to use the survey form prepared by your organisation/institutions. The survey forms should be prepared by your institution and should have been pre-tested in the field before you use it .

- the survey is not a health/development programme but may lead to one.
- make no promises.
- \* A note of caution in preparing and using survey forms.
- \* A survey should attempt to get the information that is going to be most useful to the community and the project. Do not make the survey long and complicated.
- \* Do not ask just for the sake of asking, only ask necessary questions.
- \* The surveys should not take up a lot of the villagers time. They are busy people.
- \* Community people are often over-surveyed. (especially low income groups) but seldom see any real benefits. Keep information gathering as informal as possible.
- \* If you are already familiar with your community, you may wish to do the survey only to update your information.
- \* Do not start an enquiry unless you have the intention and possibility of following through with action programmes at a later stage.

Otherwise:

- you raise people's hopes
- they become disillusioned and disappointed
- it is hard to start the next time.

REFER THE MODEL SURVEY FORM ATTACHED AS ANNEXURE

How to conduct survey?

Select Area:

In order to start your survey you must define a locality/localities to work in, since you cannot possibly cover the entire project area. Some factors to help your selection:

- nearby to your subcentre you can closely supervise the activities especially in the initial stages.
- an area where little development activity has taken place, and where low income groups reside.
- do not select an area in the main market, because it does not represent the real village situation.



## SELECT HOUSEHOLDS/COMMUNITY

- \* If for e.g. there are 2000 households in the project area, you will need to start in a smaller number to start with - maybe 50- households in the first neck of your work.

Begin with those persons who have shown the most interest - and are ready to work with you. If you remember, you identified some of these households when doing the community profile.

- \* try to conduct the survey with a cross section of the community, so as not to have a one-sided view of the community problems and possibilities. It is best to get opinions from a variety of people. Extensions workers and other agencies can give you information on the kinds of programmes they are carrying out in the area, and their view points.

## SURVEY AND WITH WHOM TO TALK TO:

- \* Village men and women (his may have to be done separately)
- \* Official and unofficial leaders
- \* Government extension workers
- \* Village panchayat officials
- \* Younger and older people
- \* Co-workers (CHVs) and others .....

- Once you have selected the families/household persons whom you wish to interview, find out when they are free and set up a time convenient for them to meet with you.
- You may have to meet people in the homes or in their place of work, but it is better to meet with them privately and separately so that you can really talk with them. A lot of people around you is very distracting.
- Carry out the survey by interviewing local people.

It may be good to involve interested local people to assist you in survey work. (CHVS) They know the community well, and people may talk more freely with them. It is also a way of making them aware of local problems, and getting their participation and co-operation early in working with the community.

But at the same time you must be careful whom you select, or you can have a very biased view.

(Formulating and asking questions)

(a) prepare for the interview:

(b) become familiar with the survey form, so that you don't have to read it out stiffly.

- \* prepare four to five questions which will help you get a dialogue started.



### (c) Conducting the Interview:

Prepare the person(s) to be interviewed by telling them your name and explaining what your purpose is. Also stress these points.

- the survey is not a health/development programme but may lead to one.
- make no promises.
- \* chat informally, build rapport and put the person at ease.
- \* Begin with open questions, (the ones you have prepared) e.g. How are you? Where are the children? where is your mother? what are you busy doing? How were your crops this year?
- \* you may request permission to write down the replies at this point, once you have got a conversation started and people have warmed up.
- \* keep questions short, simple, and direct.
- \* do not ask big general questions that may be difficult to answer.

Keep questions specific e.g.:

#### Less Appropriate

What is grown by farmers

What foods are generally given to children?

- \* try not to imply, suggest, or encourage a particular response.
- \* Let the person come out with their own real feelings and needs. Remember that what people initially express as their need is often a preliminary reaction, and should not be taken as conclusive.

#### More Appropriate

What vegetables do you grow in your backyard

What does your child eat daily?

- \* you may have to go back over some questions and answers again: as it often takes people a while to warm up.
- \* Ask people what they consider as their most important problem.
- \* Thank people for taking part, and say a friendly 'Namaste'

- \* Probe each reply in greater detail  
Ask questions that get people thinking in a positive way.  
Besides talking about their problems/needs, get them thinking about solutions, or ways of dealing with the problems, and what resources there are in the community to do this.
- \* If you think you will need to return for more information, request permission to do so.
- \* On your return visit, you need to build rapport again, before getting further information.
- \* You may have to go back over some questions and answers again, as it often takes people a while to reply correctly.

#### TIPS FOR RECORDING INFORMATION:

- (a) When recording, do not produce notebooks early in the dialogue. After conversation has been initiated and people are warming up, ask whether you can write answers, and explain why this is helpful.
- (b) When recording carry a notebook to write down observations, problems, peoples ideas, and solutions, etc.
- (c) Give attention in recording to:  
  
Persons from whom information is being sought. Know how to contact them should you need more information, or need to follow-up.

#### 3.3. INFORMAL DISCUSSIONS:

Informal discussions are another very useful tool in assessing the actual needs of people. Follow up the formal survey with informal talk and discussions with the villagers.

- this may mean meeting with them two or three times to get a more in depth view of their real needs, their most important problems, and possibilities of solutions to their problems.
- you can also verify the information collected from the survey, with that obtained from more casual talk with various people.
- often through these discussions you gain insights which are not possible through a formal survey.
- discussions with your co-workers, and government extension agents will bring out another point of view, some of the problems, and limitations to what they can do, and what they consider is most important in the community.

#### 4) PROBLEMS TO BE AWARE OF IN ASSESSING NEEDS:

- \* Assessing needs of people is not a one time activity.



\* It cannot be completed merely through a survey done in an hour or so, or in one discussion session with members of the household.

\* It requires repeated visits because:

- often people in the first meeting may tell you what they think you wish to hear.
- people may have difficulty expressing themselves the first time, they may not have thought things through.
- due to religious beliefs, traditions, age old practices, villagers are often not aware of problems because they have always lived that way.
- they may hesitate to speak with you freely at first and may keep the most important things to themselves.

#### (5) SUMMARY

It is important for the Project Manager and his team to know their community.

- Structure & dynamics of functions and its needs, Resources available etc.

This guideline is a tool to find out the above facts. Remember this is a guideline. The information you gather gives a profile (a picture) of the kind of community you have to work with. Since the project's goals are mainly focussed on Child Survival it is natural that most of the facts you gather should be related to women and children.

#### (6) How to share this knowledge ?

Explain the project's goals to the team members. Describe the essence of survey form and explain how the information gathered are going to help.

Ask them to identify each of those tasks (data) which each one can help with.



## HEALTH EDUCATION

### 1. Definition

"Health education is a process which effects changes in the health practices of people and in the knowledge and attitudes related to such changes" (Health Education Monograph No: 21)

#### 1.1. Key -Word

Process is changing knowledge attitude and behaviour.

Emphasise change of behaviour; the ultimate objective of Education is a behavioural change, i.e. adopting a new style of life, (giving and motivating people) to the timely and judicious use of the health services provided.

Note: Most health education activities are defective because they stop at giving masses of information without measures for motivating people to the adoption of a desirable health behaviour.



## 1.2. Importance of health education

Scientific knowledge that is already available for prevention and control of diseases will remain a dead technology, unless the knowledge of its views and availability is made common knowledge and people are motivated till adopt the changes required. Health education is the process that makes it possible for people to intelligently and effectively use the fruits of technology for keeping healthy. None of our grandios health plans will make any dent on society unless health messages reach the community.

## 1.3. The Aims of health education

(i) To augment the already existing values on being healthy, with adequate and appropriate scientific knowledge on how to remain healthy, how to suspect deviations from health, and what can be done about it. In other words, dispelling ignorance about health and disease, and correcting wrong and inadequate knowledge; in de-mystifying health technology and making the attainment of health a people's activity.

(ii) To help to do something about ill health. To move beyond just knowledge about health and motivating people to do something about it at both individual level (stop smoking, changing eating habits), and the community level (improving public sanitation, organising equitable distribution of health services).

If you want lasting results:  
*POINT* but don't *PUSH*.



People will move by themselves once they see the need clearly and discover a way.

(iii) To help and motivate people to the wise and judicial use of the health services provided. (the services provided in CBPHC a programme will be grossly under utilised without some health education).

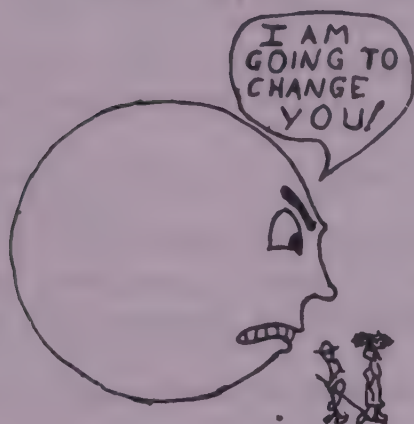
The above are the conventional ways of classifying the aims of health education. However it is worthwhile to consider another approach to this.



The conventional approach with reference to the aim of health education is to consider that the goal of health education is to change people's attitude which in turn helps them to change their health or disease related behaviour. The assumption here is that ill advised health related behaviour is largely due to ignorance, and that it is the duty of 'less ignorant' members of society to dispel their ignorance and help them to adopt the desired health promoting health diseases preventing behaviour.

#### CONVENTIONAL APPROACH

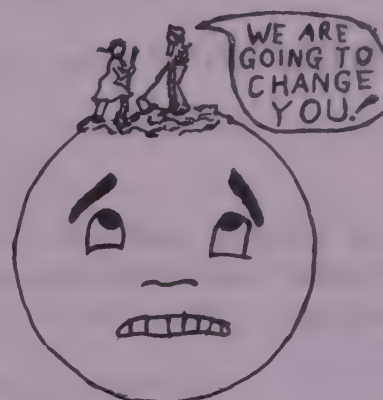
##### BEHAVIOR CHANGE



In education that focuses on behavior and attitude change, people are acted upon by the system and the world that surrounds.

#### OPPOSITE VIEW

##### SOCIAL CHANGE



In education that work for social change, people act upon the system and the world that surrounds them.

The opposite view recognises that ill health of the poor is in large part the result of a social order that favours the strong at the expense of the weak. On this premise the main goal of health education is to help the poor to gain the understanding and the skills needed to change the conditions that cause poverty and ill health.

The supporter of this view is not saying that there is no need for change in personal attitudes and behaviour. But they ask, whose attitude needs changing the most? Whose attitude and styles of life cause more human suffering/those of the poor or those of the well educated dominating classes?

They continue and say, the unhealthy behaviour of both the rich and poor results partly from the unfair social situation in which we live. So rather than trying to reform people, health education needs to focus on helping people to learn how to change their situation. The possible answer to those holding the above view is to say that the task of 'helping people to change their situation', is the function of 'social education' and not of 'health education'.



The health educator starts from the premise that both social factors (especially poverty), and ignorance play their part producing ill health in individual and communities. The task of the health educator is to dispel the ignorance factor (which includes wrong customs and beliefs), and to stimulate the social educators and engineers to change the social situation.

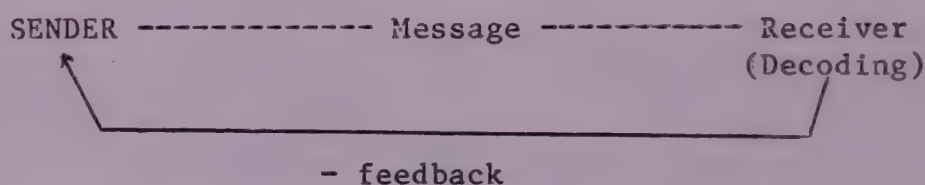
Obviously this whole matter is debatable, and a healthy debate should go on ! (See also the 'story of Raibai' given later).

However it is fairly obvious that in so far as Health Education is seen primarily only as an instructional process designed to motivate people to change and adopt a new health related behaviour, changes in behaviour will not occur from instructional alone. Concomitant social change must occur, and either the health team as a whole or other agencies have to see to this. Of course there will be some acception where desirable changes can occur without significant social changes.

## 2. Communication

Effective health education requires some understanding of some principles of effective communications. It is difficult to cover all aspects. We will mention some of the more useful aspects.

2.1. The standard model is that of 'communicator-message-reciever-coding/de coding-feedback'.



Things to note: Credibility of the communicator and the message are important. Recevier perceives very often selectively; understanding is also variable, and both are dependent on various factor such as recipient's background, past experiences, beliefs, 'world view', culture and tradition etc.

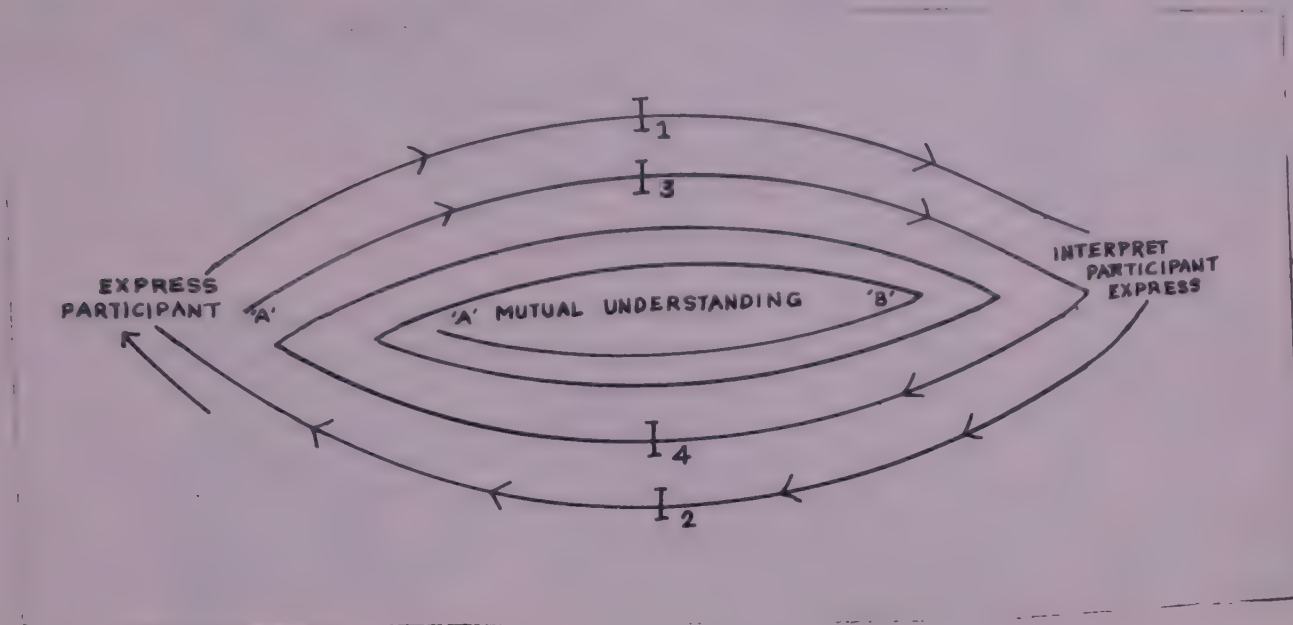
The message needs to be clear and unamibiguous as possible. The communicator has the big responsiblity in that he is the one who has to be sensitive to the condition under which the receiver responds and reacts.

## 2.2' The 'information - sharing - relationship' model

Communication is the process of sharing information and the relationship of the participants in this process.

In many ways this 'sharing' concept is better then the 'sender - receiver' model. The essential element is information and the essential process is sharing information.

### 2.3. Convergence (mutual understanding) model of communication understanding



The process begins with "and then ..." to remind us that something has occurred before we begin to look at what is going on. Participant A takes this into account before he shares information (1.1) B interprets the information which A has created to express his thoughts then B responds by creating informations (1.2) and then expresses himself again with more information (1.3) about this same topic. B interprets this and this becomes (1.4) until they are satisfied that they have reached a mutual understanding of each other meaning for the topic and discussion.

### 2.4 Roles of 'Believing', 'Creditibility', 'Certainty', Consistency.

Believing is accepting the information someone shares with us as valid, and it is also accepting the person who shares the information as sincere.

Both the creditibility of the message, as well as the creditibility of the source are important in the process of communications. And it is important to distinguish one from the other, e.g. a mother may be told by a paediatrician that a child should be started on additional foods at six months of age, and she might believe that the doctor is sincere and telling her the truth, and yet she may not believe that it would be harmless to give foods other than milk to her child when she is as young as six months in age.

Credibility is very important when our purpose is to change someone's basic beliefs about the 'world' in which he lives - his configuration of customs, beliefs, traditions. The validity of a belief is dependent degree of 'certainty' about it, and also how consistent and 'fitting' it is to other related beliefs on the subject. (Ruth Benedict's 'Cultural Fit').

For some people certainty is more important than consistency. To make communication more effective, it is necessary to find out how much information the 'receiver' (audience) has, as well as the related network of beliefs which



he or they accept as 'true'. In this sense traditions or traditional beliefs are merely accepted beliefs which have been handed down from the past. They often deal with relationships of important values to other outcomes and aspects of life. Even so, though these beliefs belong to the past, they form the material on which to build our present interpretations of the past within the context of our own immediate present day problems and situations. For this reason they are always subject to misinterpretation, reinterpretation, or change by people living today.

## 2.5 Role of psychological & sociological factors.

As indicated earlier, in Health Education we have to be concerned with changes in behaviour that we are expecting from the receiver, or audience. Therefore when we think of changes in behaviour, we must necessarily be concerned about psychological and sociological change. This involves appreciating the fact that unless our messages are understood in terms of the audiences prior experience, unless our messages help the audience to see a strong practical benefit or value in what we recommend and unless our messages achieve a certain amount of agreement and cooperation, no amount of moving messages is likely to accomplish any significant change.

## 2.6 Role of 'Rewards' changing behaviour.

A fundamental principle of learning is that a person's current beliefs, values, and actions are acquired as a result of past occurrences that have been rewarded under similar circumstances. Rewards may be material things like food or money, or psychological like a feeling of satisfaction or pride, or social such as esteem and respect that others give. A person usually thinks, feels, and behaves in ways that have been beneficial and satisfying to himself in the past.

2.7 The role of motivation: Unless there is a strong desire to learn, our educational efforts will be of no use. Maslow has pointed out that motivation is related to, and governed by, a "hierarchy of needs". Unless some of the "primary needs" are satisfied, the motivation for learning things which are unrelated to the primary needs will be low. The primary needs are hunger, protection from adverse aspects of nature, procreational needs, housing and shelter, etc. Only when these primary needs are not "a matter of anxiety or concern" will persons be motivated to learn about matters which are in the realm of secondary needs. A topic like immunization which is a 'secondary need' in the hierarchy of needs may not be of real relevance to an audience which is concerned about the 'cure' of prevalent diseases for which steps have not been taken. Learning about matters in the higher level of hierarchy of needs, is likely to occur only if the basic primary needs have been met.

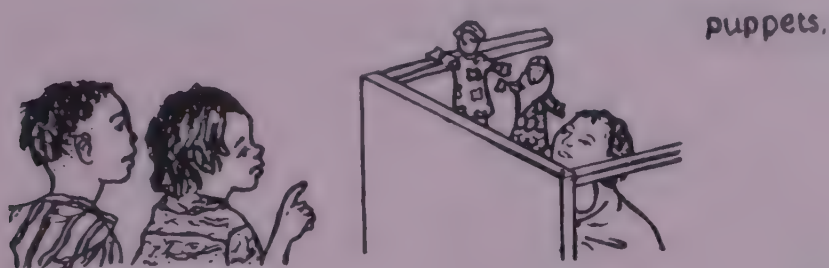
## 2.8 Channels of communication:

By channels of communication we mean various media used in communicating. There are various kinds of media and it is important to choose the right kind of media for successful communication. Broadly speaking there is 'one way' or 'two way' communication. 'One way' communication is the usual pattern such as lectures, film shows, radio messages, newspapers articles etc. Here there is no active interaction between the messenger, the message and receiver. All

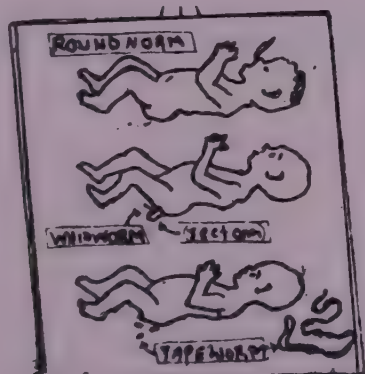


theories of communication results show that two way communication is far better. Most people use the one way method because it is easier for the teacher. The two way method requires more preparation on the part of the teacher, and 'interest and participation' from the learners. It is also possible to have a combination: i.e. it is possible to get participation from the learner if a lecture is interspaced with questions and answer sessions.

Group discussions, role - plays, dramas, Katha - Kalakshebams,. The dance drama, the street drama, use of puppets, are all effective ways of communication.



Audio-visual aids, simple visual aids, flash cards and flip charts are all very useful aids.



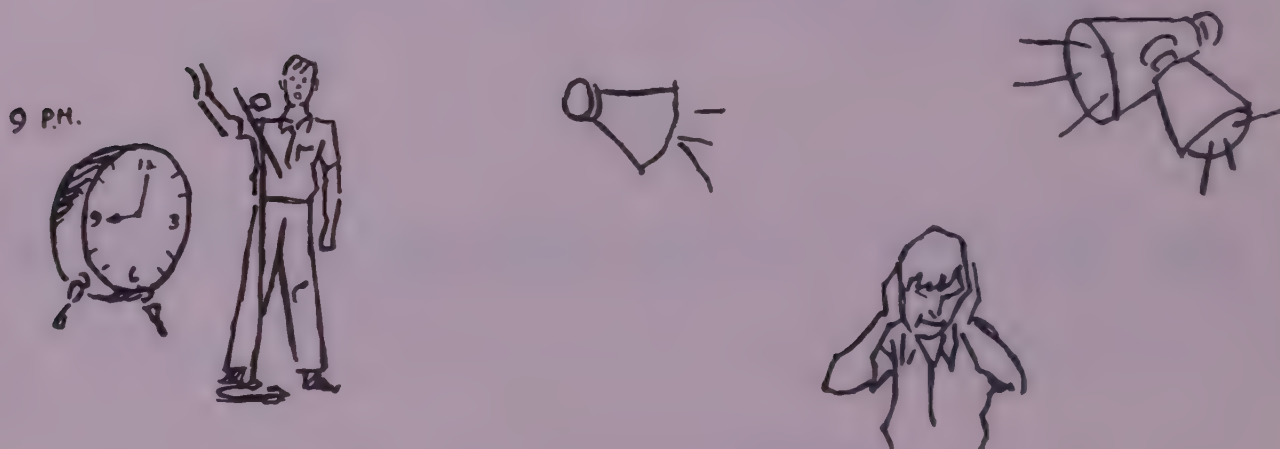
It is important that aids which have been prepared by outside experts should never be used without pre-testing with the community you are working with.

A list of teaching aids and their merits and demerits are given in the appendix.

## 2.9 Barriers to communication

These may be classified as

- (a) Physiological - defective hearing poor lighting etc.
- (b) Psychological - emotional disturbances, distraction due to various personal or family problems bothering the learner.
- (c) Environmental - distracting noises, poor lighting, poorly functioning loudspeakers etc.
- (d) Organizational: inconvenient timing; unduly prolonged sessions leading to boredom and fatigue.



- (e) Quality of the teaching aids: such as badly conceived posters, flash cards, lack of pretesting, badly organized group discussions, role-plays, etc. Research has shown that it is not the kind of teaching aid that matters, but the way the aid is used makes all the difference.
- (f) Cultural: Not being sensitive to the local customs and beliefs and traditional ways of dealing with health problems, etc.
- (g) Message and action required being far removed from 'real life' situations, as illustrated in the following:



## THE STORY OF RAIBAI

Raibai Dabole, a woman of 30 years brought her 1 1/2 year old baby to our clinic in Kanhapur. The child had severe malnourishment with broncho-pneumonia. We advised immediate hospitalization of the baby, explained to her

that the child would not survive unless she takes him to hospital and kept him there for about a week. She left the clinic with remarks that indicated that she was displeased and unconvinced about our advice. We cursed her and said "these rural people do not understand the value of a child's life". They are callous about it, and that is why children die like flies. Without bothering about the child's life they produce new babies. Thus our birthrate and the infant mortality rate both go high...

Next day this baby was lying near a public well, with convulsions. By the time we reached, the baby was dead. We did not find the mother around. We were told that this 1 1/2 year old was left in the care of a 4 year old elder child and mother had gone out. Our view about the stupidity of our people further strengthened.

Next time when Raibai came to our clinic we scolded her for such utterly negligent and callous behaviour. Then she told her side of the story:

She was a widow with 3 children, exploited and harrassed by everybody, she was leading an unsupported life. She was the only wage earner in the family and was waiting for her elder son, (seven years then) to grow up and share her burden. When we advised her to hospitalize the younger child, she had a difficult choice, if she had to stay in hospital with the baby for a week, the 2 older children would starve. Older children were valuable to her because they would reach the earning age earlier. She decided to save the older children at the risk of the youngest one's life. At the time of the death of the baby, she had gone to the fields to earn her daily wages leaving her baby in the custody of the older sibling, four years old. Was it irritational behaviour?

(Source: Abay and Rani Bang:

`The other side of the Health Education in `under the Lens - MFC Publication)

h) Non-accessibility to required services, when motivated to use it.

Eg. If woman has decided to wear an I.U.C.D. She shared her easy access to it. difficulties, and a negative multiplier effect because of inter village communication.

3. Relating the "communication process" to the "adoption process".

(See annexure ). It will be recalled that there are five stages that a person goes through before accepting a new idea or practice,. Remember that the ultimate objective of an educational process is that there should be a behaviour change i.e. the adoption of new practice.



It will be helpful to consider which of the modes of communication we discussed will be applicable to the various stages of the adoption process. In the awareness creation, and interest generation stage, mass media such as radio, films, posters, newspaper articles are the most useful. But remember that this mass media will not be sufficient or effective in taking the person to the steps of 'evaluation', 'trial adoption' and finally 'authentic adoption'. Very often people think that if they show a lot of films or organise and send out a lot of radio messages, and publish newspaper articles, they have carried out effective health education. They do not realise that most people who have been beneficiaries of these mass media would not necessarily have changed their attitude, or adopted a desirable health practice.

"Awareness of family planning programmes is nearly universal, but acceptance is estimated to be only 35%. The role of extension personnel at village level becomes crucial for converting into acceptance. This needs inter-personal communication skills". (Revised Strategy for National Family Welfare Programme-Summary; 7.13, Page 28). This quotation aptly gives the clue as to what is to be done, and the communication strategy or media are required to help people to move from the stage where they have developed sufficient interest. At this point there is a critical stage of ambivalence, a situation where the person contemplating the adoption of a new or strange practice, is looking for more information, clarifications to questions which he dare not ask in public, but longs to have access to a knowledgeable person where he can clear his/her doubts in a confidential face to face, friendly, supportive, non-threatening atmosphere. Hopefully, one or other of the members of the health team should be the person who have by now developed such a warm relationship with the members of the community, that the person struggling with the problem of ambivalence can turn to them. And God help must if the member of the team fails to match up to the situation!

This is also the time that the individual is looking for peer group approval (from usually the important members of the family), as well as "social approval" from other important members of the community, such as the influential leaders or other members of the subgroup that he/she belongs to.

While some of it can be dealt with in a strictly inter-personal situation, the social approval may need educational and motivational inputs at the small group level through group sessions, through discussions or role-plays, use of satisfied customers, etc.

#### 4. Opportunities for Health Education

4.1 There are endless opportunities for health education, as for example in obvious places like the home, a clinic, the out patient departments, schools, colleges, various types of clubs, community groups in a village etc. However, There are certain opportunities when the receptivity for learning is likely to be very high, as for instance when child is suffering from diarrhoea, and you happen to visit the home and the mother is worried that she cannot go to the hospital, (no money, too far), and the local healer is away. This is a good time to make the ORS with the mothers help, without at that time bothering to say anything about the reasons for what you are doing. After having started

the treatment and waiting for the relief of anxiety, at the opportune moment you can take the time to tell her more about the causes and prevention of further episodes of diarrhoea. Note, that you meet the acute need of the situation first and then choose the opportune moment to educate later. You should not miss the opportunity.

Be aware of inopportune occasions also. This danger is quite common with health workers who have rigid work schedules and programmes. A health worker has set herself a programme of teaching the importance of antenatal care in the home of the newly discovered pregnant lady and finds that the family is busy dealing with the delivery of a calf.

4.2 Application and use of health education at the small group village community, and clinic/hospital level should be more of a planned activity, the responsibility being taken by the Programme Managers and the field supervisors.

The basis for this planned approach is:

- (a) even individuals change only if there is some legitimisation by the community, opinion leaders, peer groups and elders.
- (b) having mentally accepted a change, individuals require specific information to act on the desired behaviour, eg. for bringing children for immunization, the parents should receive specific instructions as to where and when the service is available.

## 5. Guidelines for teaching the CHV

Training objective: At the end of the session, the CHV should have some general idea of the learning and change process and be able to carry out health education using specifically the following tools of communication:

- (i) visual aids, especially the flash cards, flip charts; story songs;
- (ii) group approaches with role plays, group discussions.
- (iii) assist the other members of the team in identifying appropriate opinion leaders, organising small group meetings, especially the women's group.

(Note: the content of what she teaches will be what she has learnt on MCH etc)

Methodology: Mini-lecture and actual practice sessions.

Assessment: Observation and group discussion on use of aids.

Duration: 3 1/2 hours

\* See Annexure for example of a story which can be used as a good example of building on the local people's customs, beliefs and even getting down to using the local language or 'jargon'



## 6. Summary:

Most health educational activities have concentrated on giving a mass of information through a variety of the available channels but have not done enough to see that the desirable action has been taken. An understanding of the stages involved in adopting new ideas and practices, and which channel of communication is appropriate to the various stages enables us to be more effective.

A behavioural-change oriented health educational activity has to start from where people are. The proposed change in behaviour will be accepted and assimilated only if it helps people to gain new satisfactions from adopting the new practice. Helping people to move on from the stages of 'awareness' and 'interest' needs a one-to-one personalised dialogue and counselling and also very often social approval and legitimisation. This is a task that require great ingenuity, competence, and humility.



## MANAGEMENT OF MINOR ILLNESS

### 1) FEVER

- is usually due to infection by- disease-causing germs.
- when germs enter the body fights these germs. Fever is caused by the fight between germs and the bodies defense mechanism. So fever by it self is a good sign. During fever it is important to drink plenty of fluids. Children must be given something to eat during fever- (rice or rava kanjee) do not starve children who are having fever; you must coax them to eat - this requires time and patience.

#### Treatment

Adults - PARACETAMOL TABLETS - 1-2 tabs every six hours or ASPRIN TABLETS

Children = Crocin Syrup 1/2 to 1 1/2 tsp every six hours.

#### Precautions:

- i) DO NOT TAKE MORE THAN 8 TABLETS IN 24 HRS
- ii) ASPIRIN SHOULD NOT BE GIVEN TO PEOPLE WHO HAVE BURNING PAIN IN THE STOMACH
- iii) IN THE CASE OF CHILDREN WITH FEVER - if below 3 months of age - do not treat at home.

#### WHAT NOT TO DO IN TREATMENT OF FEVERS:

- i) Do not cover patient with extra clothing and blankets-this will only make the body more hot
- ii) DO NOT TREAT ANY AND EVERY FEVER WITH ANTIBIOTICS SUCH AS AMPICILLIN, GARAMYCIN etc. This is DANGEROUS FOR HEALTH as it weakens the body's own defense mechanism.

### 2) CONVULSIONS:

- i) Definition: Convulsions are jerky movements of the arms, legs and face which the individual cannot control. They usually last less than 1-2 minutes and may be accompanied by varying periods of unconsciousness.

Convulsions can be caused by high fever (usually over 103 degree F) usually these convulsions i.e. the convulsions caused by high fever are not harmful to the body.

Children are much more likely to get convulsions from high fever than adults.

## ii) Treatment:

What can you do about convulsions caused by high fever?

- \* BRING DOWN THE BODY TEMPERATURE by sponging the body with luke warm water.
- \* Give plenty of liquids to drink.
- \* Refer the child to a doctor - although.
- \* Convulsions caused by fever are not harmful - a doctor must examine the child as soon as possible to make sure that the convulsions are not caused by other more dangerous illnesses, e.g. meningitis.

## iii) Immediate first-aid measures for convulsions.

- make sure the patient is lying down.
- keep spoon in his/her mouth to prevent the tongue being bitten.
- if the patient loses consciousness transport him/her to the nearest medical facility immediately.

## 3) DIARRHOEA - see chapter on oral re-hydration.

REMEMBER THAT FOR MOST DIARRHOEAS - ANTIBIOTICS ARE NOT NECESSARY

## 4) VOMITING:

Vomitting may be due to simple infections like worms or more serious illnesses like appendicitis or gut obstruction. How to distinguish these two.

### SIMPLE

- i) Usually no abdominal pain or very little pain is present.
- ii) Usually the belly or abdomen does not look swollen or disabled.
- iii) No change in consciousness
- iv) Vomiting is usually not forceful
- v) Can be controlled by starvation for about 2 hrs followed by giving small amounts of liquids every 15 minutes.

### SERIOUS

- Usually severe cramping abdominal pain is present
- Abdomen or belly can be distended (swollen) or may be hard.
- Can be associated with drowsiness or loss of consciousness.
- Vomiting is very forceful may shoot out a metre or more, may be green in colour and may smell like stool.
- Cannot be controlled. Patient vomits even small amount of liquids



## WHAT TO DO ABOUT VOMITING

- 1) if signs of serious illness are present refer immediately.
- ii) if no serious signs are present starve for about 1-2 hrs; then start giving small amounts of clear liquids like glucose water every 15 mts - if this is retained, then try other foods like rice or ragi conjee etc.

## 5) COUGH

- colds and coughs are very common childhood problems.
- parents and children often have colds and coughs at the same time.
- if cough is not associated with high fever and difficulty in breathing it can be treated at home. Simple "cough mixtures" can be made at home as follows.

### (i) Ginger and Honey Mixture:

Take 1" piece of fresh ginger, remove skin and crush well, add 1/2 glass of boiled cooled water mix well and strain, add honey to the strained juice less honey for adults, more for children, keep in covered bottle and use three to four times daily for cough.

### (ii) Honey, Ginger and Tamarind Leaves:

One handful of tender green tamarind leaves to one glass of water to 1/2" piece of fresh ginger and honey to taste. Boil as many glasses of water as you have the tamarind leaves, to get a 1:1 proportion. Wash tamarind leaves well. Remove boiled water from fire add tamarind leaves to hot water and add ginger also after cleaning and crushing - leave covered overnight, next day strain, add honey to the strained liquid, bottle and use 4-6 times daily for coughs.

## 6. NOSE BLEEDS

### HOW TO STOP NOSE BLEEDS;

#### (1) Sit quietly.

#### (2) Pinch the nose firmly for 10 minutes or until the bleeding has stopped.

If this does not control the bleeding .....

Pack the nostril with a wad of cotton, leaving part of it outside the nose.

If possible, first wet the cotton with hydrogen peroxide, vaseline. Then pinch the nose firmly again. Do not let go for 10 minutes or more.

Leave the cotton in place for a few hours after the bleeding stops: then take it out very carefully.



Do not dig into the nose or try to remove clotted blood. Bleeding will start again.

If a person's nose bleeds often, smear a little vaseline inside the nostrils twice a day.

Eating oranges, tomatoes, and other fruits may help to strengthen the small blood vessels so that the nose bleeds less.

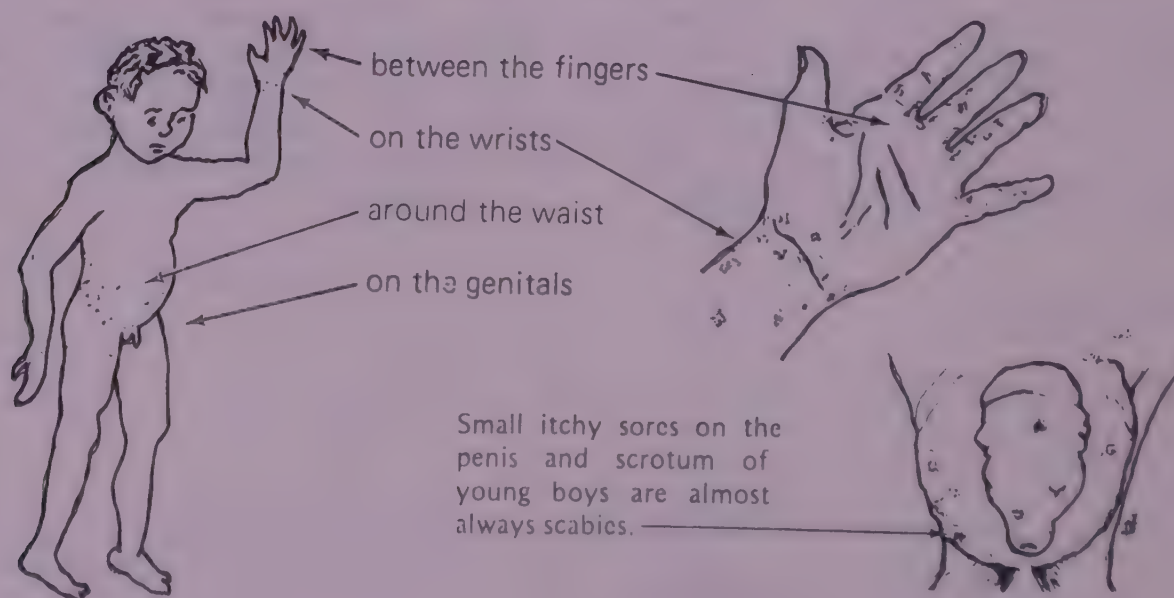
In older persons especially, bleeding may come from the back part of the nose and cannot be stopped by pinching it. In this case, have the person hold a cork, corn cob, or other similar object between his teeth and, leaning forward, sit quietly and try not to swallow until the bleeding stops. (The cork helps keep him from swallowing and that gives the blood a chance to clot).

## 7. SCABIES

Scabies is a common skin problem especially among children but also in adults. People get scabies because of inability to keep clean - e.g. where there is water shortage and a daily bath is not possible.

How to diagnose scabies

- very itchy
- rash between the fingers but can and does spread to other areas of the body.



How to treat

### (a) Home remedy

Paste made with neem leaves and turmeric ground together - apply over affected areas, kept on overnight and then bathe with hot water.

(b) Benzyl Benzoate Solution - applied overnight then followed by a hot bath.

THE MOST IMPORTANT PART OF THE TREATMENT IS TO WASH ALL CLOTHES ALSO IN HOT WATER AND DRY IN THE SUN. If this is not done the infection recurs.



#### 8. WOUNDS:

Cleanliness is of first importance in preventing infection and helping wounds to heal.

To treat wound - First wash your hands very well with soap and water.

Then wash the wound well with soap and boiled water.

When cleaning the wound, be careful to clean out all the dirt. Lift up and clean under any flaps of skin. You can use a clean tweezers or other instruments to remove bits of dirt, but always boil instruments first to be sure they are sterile. If possible, squirt out the wound with boiled water in a syringe or suction bulb.

Any bit of dirt that is left in a wound can cause an infection.

Never put animal or human faeces or mud on a wound. These can cause dangerous infections, such as tetanus.



DO NOT DO THIS

A clean wound will heal without any medicine.

If a person gets a cut, scrape or wound, give him an injection of tetanus toxoid immediately. If he has not been immunized against tetanus, give him one injection each month for the next two months.

#### LARGE CUTS: HOW TO CLOSE THEM

A recent cut that is very clean will heal faster if you bring the edges together so the cut stays closed.

Close a deep cut only if all of the following are true:

- the cut is less than 12 hours old
- the cut is very clean and
- it is impossible to get a health worker to close it the same day.

Before closing the cut, wash it very well with boiled water and soap. If possible, squirt it out with a syringe and water. Be absolutely sure that no dirt is left hidden in the cut.

#### INFECTED WOUNDS, HOW TO RECOGNIZE AND TREAT THEM

A wound is infected if:

- it becomes red, swollen, hot and painful
- it has pus
- or if it begins to smell bad

The infection is spreading to other parts of the body if:

- it causes fever
- there is a red line above the wound
- or if the lymph nodes become swollen and tender. Lymph nodes - often called 'glands' - are little traps for germs that form small lumps under the skin when they get infected
- swollen lymph nodes behind the ear point to an infection on the head or scalp, often caused by sores or lice, or German measles may be the cause.
- Swollen nodes below the ear land on the neck indicate infections of the ear, face, or head (or tuberculosis)
- Swollen nodes below the jaw indicate infections of the teeth or throat
- Swollen nodes in the armpit indicate an infection of the arm, head, or breast (or sometimes breast cancer)



- Swollen nodes in the groin indicate an infection of the leg, foot, genitals, or anus.

#### Treatment of infected wounds:

- put hot compresses over the wound for 20 minutes 4 times a day. You use hot water with salt, soap or potassium permanganate for the compress.
- Keep the infected part at rest and elevated (raised above the level of the heart).
- If the infection is severe or the person has not been vaccinated against tetanus, an antibiotic like penicillin and vaccination against tetanus must be given by a qualified health worker.

Warning: if the wound has a bad smell, if brown or grey liquid oozes out, or if the skin around it turns black and forms air bubbles or blisters, this may be gangrene. Seek medical help fast.

Wounds that are most likely to become dangerously infected.

- \* dirty wounds, or wounds made with dirty objects.
- \* puncture wounds and other deep wounds that do not bleed much
- \* wounds made where animals are kept: in cowsheds pigpens, etc.
- \* large wounds with severe mashing or bruising.
- \* bites, especially from dogs, pigs or people
- \* bullet wounds.

Special care for this type of 'high risk' wound:

- (1) Wash the wound well with boiled water and soap. Remove all pieces of dirt, blood clots, and dead or badly damaged flesh. Squeeze out the dirt using a syringe or suction bulb.
- (2) Soak the wound in water with potassium permanganate (1 teaspoon to a bucket). Then paint the wound with gentian violet and cover it with a clean bandage.
- (3) If the wound is very deep, or if it is a bite, or if there is a chance that it still has dirt in it, use an oral antibiotic if necessary. The best is ampicillin, in capsules (in the most serious cases, injections.) If patient cannot afford ampicillin, penicillin, tetracycline, or a sulfa may be given by a qualified health worker.
- (4) Never close this type of wound with stitches or 'butterfly' bandages. Leave the wound open.

The danger of tetanus is very great in people who have not been vaccinated against this deadly disease. To lower the risk, a person who has not been vaccinated against tetanus should use penicillin immediately after receiving a wound of this type, even if the injury is small.

If a wound of this type is very severe, a person who has not been vaccinated against tetanus should take large doses of penicillin or ampicillin for a week or more. Tetanus antitoxin should also be considered - but be sure to take the necessary precautions in its use.

#### (9) BURNS:

##### Prevention:

Most burns can be prevented. Take special care with children.

- \* Do not let small babies go near a fire.
- \* Keep lamps and matches out of reach
- \* Turn handles of pans on the stove so children cannot reach them.



##### Minor burns that do not form Blisters (1 degree)

To help ease the pain and lessen damage caused by a minor burn put the burned part in cold water at once. No further treatment is needed. Take aspirin for pain.

##### Burns that cause blisters (2nd degree):

Do not break blisters.



DO NOT DO THIS



If the blisters are broken, wash gently with soap and boiled water that has been cooled. Sterilize a little Vaseline by heating it until it boils and spread it on a piece of sterile gauze. Then put the gauze on the burn.

If there is no Vaseline, put some gentian violet, leave the burn uncovered. If signs of infection appear - pus, bad smell, fever, or swollen lymph nodes - apply compresses of potassium permanganate solution 3 times a day. If potassium permanganate is not available, you can use warm salt water (1 tea spoon salt to 1 litre water.) Boil both the water and cloth before use. With great care, remove the dead skin flesh. You can spread on a little antibiotic ointment such as Neosporin. In severe cases, an antibiotic such as penicillin or ampicillin by mouth may be given by a qualified health worker.

Deep burns (3rd degree) that destroy the skin and expose raw or charred flesh are always serious, as are any burns that cover large areas of the body. Take the person to a health centre at once. In the meantime wrap the burned part with a very clean cloth or towel.

If it is impossible to get medical help, treat the burn as described above. If you do not have Vaseline, put some gentian violet and leave the burn in the open air, covering it only with a loose cotton cloth or sheet to protect it from dust and flies. Keep the cloth very clean and change it each time it gets dirty with liquid or blood from the burn. Penicillin may be given by a qualified health worker.

Never put grease, fat, hides, coffee, herbs or faeces on a burn.

Special precautions for very serious burns.

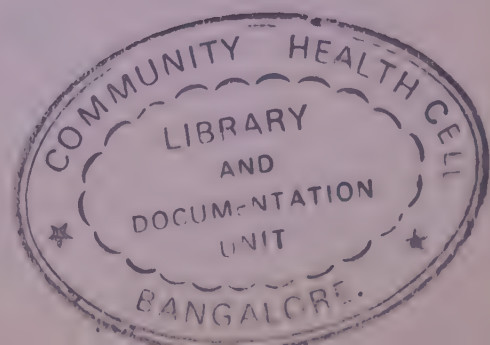
Any person who has been badly burned easily go into shock because of combined pain, fear, and the loss of body fluids from the oozing burn. Comfort and reassure the burned person. Give him Paracetamol for the pain and code in if you can get it. Bathing open wounds in slightly salty water also helps calm pain. Put 1 teaspoon of salt for each litre of boiled (and cooled) water.

Give the burned person plenty of liquid. If the burned area is large (more than twice the size of his hand) make up the following drink. In a liter of water put half a teaspoon of salt and half a teaspoon of bicarbonate of soda. Also put in 2 or 3 tablespoon of sugar or honey and some orange or lemon juice if possible. The burned person should drink this as often as possible, especially until he urinates frequently.

#### (10) SNAKE BITE

All snakes are not poisonous, nor can they outrun man as commonly believed there are only four common poisonous snakes in India.

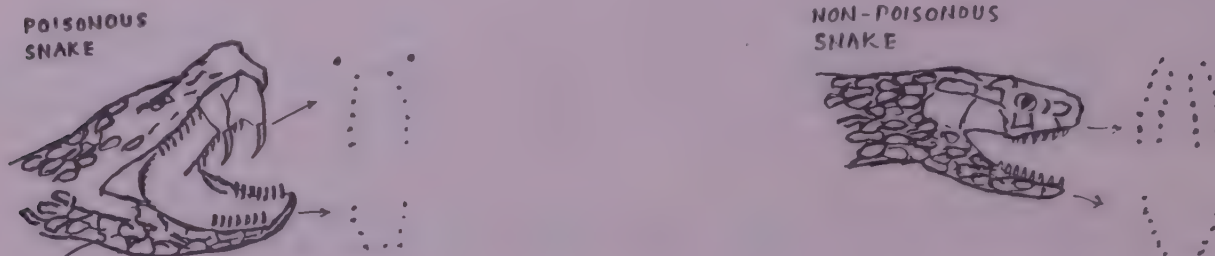
1. Common cobra (Hindi:Nag) name in your area
2. Common Krait (Hindi: bangarus) name in your area
3. Russel's viper (Hindi:Daboia) name in your area
4. Saw-scaled viper (Hindi:Phoorsa) name in your area





This snake is less than a foot long. It has a clear 'arrowhead' design on the head. Both Russell's viper and Saw-scaled viper have a triangular head and a narrow, thin neck.

When a person has been bitten by a snake, try to find out if the snake was poisonous, or not. Their bite marks are different.



Most often the bite marks are not so clear as shown in the picture. There may be just one fang mark, or just row of teeth marks, or a ragged tear at the site of the wound. When in doubt, always look for the local and general signs of poisoning, and keep the person under observation for at least one day.

The poison from cobra and krait affect the nervous system. The viper venom affects the blood and prevents it from clotting.

People often believe that certain harmless snakes are poisonous. DO NOT KILL NON POISONOUS SNAKES, because they do no harm. On the contrary, they kill mice and other pests that do lots of damage. Some even kill poisonous snakes.

At the site of the snake bite: local signs

These signs appear within 15 to 30 minutes of the bite.

- \* Pain - may be quite severe and may last for many days.
- \* swelling - depends on the amount of poison that has entered the blood. In case of viper bites, pain and swelling at the site of the bite is more severe.
- \* bleeding from the bite: this is more common in case of viper bite
- \* infection and gangrene may also develop.

General signs: These develop from 15 minutes to one hour after the bite.

Cobra and Krait: affect the nervous system.

- \* drowsiness
- \* weakness of the muscles especially the muscles around the eye.
- \* the person may start seeing double (double vision) and may develop a squint.
- \* paralysis of muscles.
- \* respiratory failure may lead to death.

Vipers: affects the clotting of blood.

- \* headache, giddiness
- \* nausea, vomiting
- \* cough with bloodstained phlegm
- \* bleeding under the skin
- \* signs of shock if there is too much bleeding.

Treatment for poisonous snakebite:

- (1) Stay quiet; do not move the part that has been bitten. The more it is moved, the more rapidly the poison will spread through the body. A person who has been bitten on the foot should not walk.
- (2) Tie a cloth around the limb, just above the bite. Do not tie it very tight, and loosen it for a moment every half hour.
- (3) With a very clean knife (sterilized in a flame) make a cut into each fang mark: about 1 cm long and 1/2 cm . deep.
- (4) If you can get ice, wrap pieces in thick cloth and pack these around the limb that was bitten.
- (5) Tetanus toxoid injection must be given to prevent tetanus.
- (6) If signs of infection develop, penicillin may be used.
- (7) If a person develops any of general signs described above, refer to the nearest health facility immediately.

Poisonous snake bite is dangerous. Send for medical help at once- but always do the things explained above at once. Most folk remedies for snakebites do little if any good. Never drink alcohol after a snakebite. It makes things worse.

Note : you can get polyvalent antivenin which is effective against the above snakebites from:

The Haffekine Institute  
Acharya Dande Marg  
Parel  
Bombay - 400 012 (India)

For further reading on this refer First Aid chapter in "Where There Is No Doctor."

#### HOW TO TEACH THESE LESSONS TO CHV'S : POINTS TO REMEMBER

- i) Find out from CHVs what illnesses occur commonly fever, cough, diarrhoea and vomiting are common illnesses everywhere.
- ii) Ask how common cuts and bruises and poisonous bites are.

- iii) Based on their response make up a list of common illnesses which they can treat at village level.
- iv) Check this list with your hospital staff
- v) Teach one illness and its treatment at a time.
- vi) Make sure you teach CHVs when they should refer an illness and make sure they understand the procedure for referral.
- vii) Make sure your hospital staff understands the referral procedures from the field to the hospital- you will have to organise
- viii) Make sure you also organise a follow up plan for any person treated at the hospital. How is the person doing after hospital treatment? Convey this information back to the department concerned,
- ix) Use case study of actual patient from the community to teach this lessons. This always generates and sustains interest of the CHVs.
- x) Be sure to emphasise HOW TO PREVENT THESE ILLNESS - e.g. when teaching about diarrhoea that simple hand washing before meals can be decrease the number of times one gets diarrhoea. STRESS THE IMPORTANCE OF GOOD NUTRITION IN FIGHTING DISEASE AND HELPING BABY TO RECOVER QUICKLY.



## TUBERCULOSIS

### 1. Prevalence:

2% of the population suffer from TB. Among these the number of persons with infectious tuberculosis is 0.4% (In a population of 1000 there may be 4 infectious persons) from whom disease can spread to others.

THESE ARE THE PERSONS WHOM WE ARE CONCERNED WITH

Therefore these people are to be identified

- educated
- motivated to get regular treatment

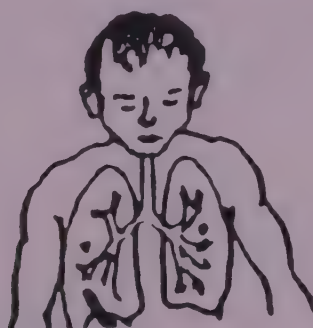
Calculate the prevalence in your area:

Population...

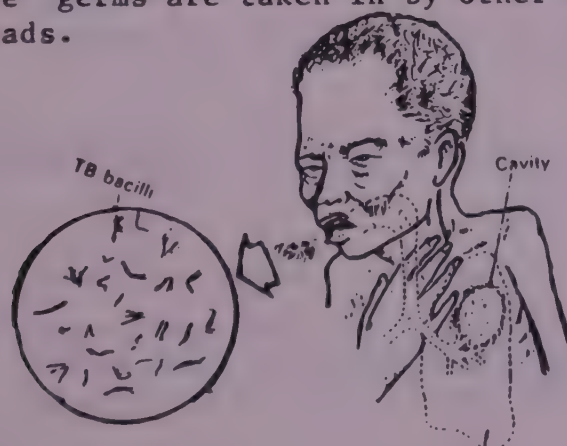
Infectious persons ...

### 2. Care and Prevention:

TB is caused by germs and the commonest part of the body affected is the lungs.



When a person suffering from TB coughs he/she brings out millions of TB germs; these germs are taken in by other persons while breathing, and the disease spreads.



#### 4. Importance of regular treatment.

- \* TB IS CURABLE
- \* PEOPLE DIE IF THEY ARE IRREGULAR WITH TREATMENT
- \* PEOPLE CAN CONTINUE TO WORK IF REGULAR WITH TREATMENT.
- \* FREE EFFECTIVE DRUGS ARE AVAILABLE FROM THE GOVERNMENT.

#### 5. The CHV needs to know

- \* Malnourished Children get T.B. more often.
- \* TB IS INFECTIOUS
- \* TB PATIENTS CAN BE RECOGNISED EASILY FROM CERTAIN CARDINAL SYMPTOMS
- COUGH FOR TWO WEEKS OR LONGER
- LOW FEVER OF TWO WEEKS OR LONGER
- WEIGHT LOSS
- NIGHT SWEATS
- BLOOD IN SPUTUM
- \* TB IS PREVENTABLE AND HOW TO PREVENT IT
- \* TB NEEDS REGULAR TREATMENT
- \* TB DRUGS ARE AVAILABLE FREE OF COST FROM GOVERNMENT



The CHV has to do - the following:

- \* Advise any person suffering from any two of the above symptoms to go to the hospital or subcentre.
- \* Educate the patient and family about preventive measures.
- \* Motivate the patient to take regular treatment.
- \* Advise on supportive measures applicable at family level.
- \* Teach persons suffering from TB, (and their families), that they should
- COVER THEIR MOUTH WHILE COUGHING OR SNEEZING;
- NOT SPIT ANYWHERE BUT INTO A CONTAINER WITH BITS OF PAPER TO BE BURNT LATER;
- COVER WITH SAND THE SPUTUM, IN CASE HE IS FORCED TO SPIT WHILE AWAY FROM THE HOUSE.
- SLEEP SEPARATELY, ESPECIALLY AWAY FROM CHILDREN, AND IN FRESH AIR
- SEE TO IT THAT ALL THE CHILDREN IN THE HOUSEHOLD ARE GIVEN BCG VACCINATION
- ENSURE THAT SWEEPING OF THE HOUSE IS AFTER SPRINKLING FLOOR WITH WATER (WET MOPPING IS IDEAL)
- \* Use flash card (or Flip Chart), to explain how tuberculosis spreads.
- \* STRESS IMPORTANCE OF BCG VACCINATION
- \* DEMONSTRATE HOW TO DISPOSE SPUTUM

DESIRABLE ACHIEVEMENT TARGET FOR CHV: SHE SHOULD MOTIVATE ALL INFECTIOUS TB PATIENTS (APPROXIMATELY FOUR ONLY) TO BE ON REGULAR TREATMENT FOR A MINIMUM PERIOD OF ONE YEAR

## LEPROSY

### 1. CAUSE

- \* LEPROSY IS NOT DUE TO A CURSE.
- \* LEPROSY IS NOT A HEREDITARY DISEASE
- \* LEPROSY IS CAUSED BY GERMS

LEPROSY HAS A SOCIAL STIGMA (UNFORTUNATELY)

### 2. SPREAD:

Leprosy spreads by close contact over a long period of time. Usually it takes a few years before a person develops Leprosy. Only 5% of the people in a population do not have their own body protection against leprosy (susceptibility)

### 3. SIGNS

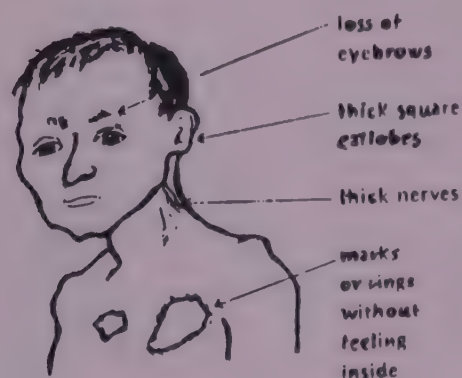
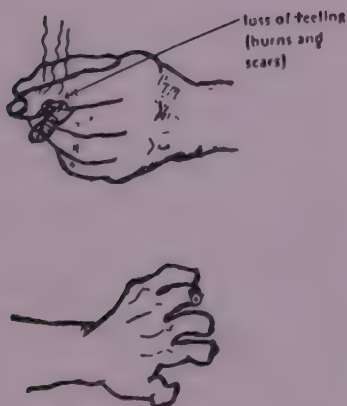
Leprosy germs attack NERVES AND SKIN

AN INSENSITIVE WHITE PATCH - on face, or buttock, back or any part of body may be leprosy.

LOSS OF SENSATION in fingers and feet.

THICKENED NERVES at elbow and back of leg.

#### POSSIBLE SIGNS OF LEPROSY





#### 4. TREATMENT

Recent advances in treatment have shortened the duration of leprosy treatment to a maximum of only 2 years.

REFER ANY PERSON WHOM YOU SUSPECT IS HAVING LEPROSY TO A DOCTOR. LEPROSY IS CURABLE.

#### 5. Assessment:

By discussion.

#### 6. CHV Needs to know

- \* Leprosy is curable
- \* Early detection & treatment prevent deformity and the associated stigma.
- \* How to detect leprosy from signs and symptoms
- \* Refer persons suspected of having leprosy to a doctor
- \* Explain that leprosy is a curable disease
- \* TEACH with flash cards/other aids the signs of leprosy
- \* STRESS the importance of early detection and regular treatment.

## ENVIRONMENTAL SANITATION

### Introduction:

Note: This chapter deliberately brief; our intent is not to belittle the importance of environmental sanitation in promotion of health. Rather we have given importance to a few practical measures which can be achieved by all in a village setting.

Social sanitation is not a virtue among us. We may take a kind of a bath, but we do not mind dirtying the well or the tank or the stream by whose side, or in which we perform our ablutions.

I regard this defect as a great vice which is responsible for the disgraceful state of our villages and the sacred banks of the sacred rivers, and for the diseases that spring from insanitation" - Mahatma Gandhi.

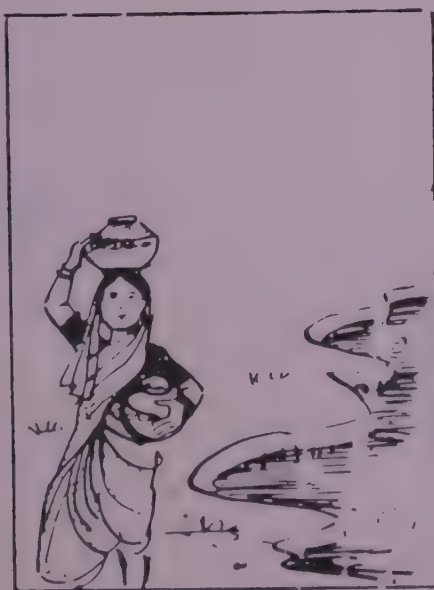
Indians have been described as the people who are fastidious about eating in private and easing in public.

Can we do something about changing this?

#### 1) Water

##### 1) Sources of water supply

Ponds, streams, wells and pipes are the common sources in our villages.



### ii) How contamination takes place

Usually ponds are more heavily contaminated than running water.

Deep borewells are generally safe, but later on the water can get contaminated by careless handling.



### iii) How to get safe drinking water.

Boiling is the most simple and effective method of getting safe drinking water.





## 2. Waste and Excreta disposal

- i) Diseases are spread by improper disposal of excreta and other wastes.
- ii) Improper disposal of excreta is responsible for worms, cholera diarrhoea, typhoid, jaundice, polio and many other diseases. In most cases flies act as the vehicle of spread.

## 3. Importance of personal hygiene.

- i) The use of soap or (any local detergent) for washing hands after defecation and before every meal is likely to prevent most illness.
- ii) Cooked and uncooked eatables should be kept covered.
- iii) Water should be boiled and then stored in closed clean containers.
- iv) A long handled cup (ladle) should be used for taking water from container.

This prevents contamination of water in the container.

## 4. How to impart this knowledge to others.

Explain to them the spread of diseases, caused by impure water, and poor environmental sanitation using visual aids.

STIMULATE a group discussion on what steps they will take to improve their village sanitation.

## **JOB FUNCTIONS OF THE PROJECT MANAGER**

### **INTRODUCTION:**

The project Manager (He/She) is a full time staff whose main responsibility is the management of the CBPHC Programme. He/She should preferably be a non-medical graduate with the ability to work with people. He/She will be the main liason between the field staff and the institution.

### **FUNCTION:**

1. Responsible to the CEO of the Institution.
2. Supervision and guidance.
  - a) Supervise and guide the field supervisors/multipurpose health workers and volunteers.
  - b) Strengthen the knowledge and the skills of the field supervisors or multipurpose health workers in their different areas.
  - c) Help and guide the field supervisor/MPHW in improving their human relations skills:
  - d) Help and guide the field supervisors/MPHW in planning and organising their programme.
  - e) Assess the work of Field Supervisor
  - f) Assess the work of CHV in consultation with Field Supervisor

### **3. Training:**

Organise and conduct training of CHVs with the help of Field Supervisor/MPHWs and hospital staff.

### **4) Team Work:**

- a) Plan, prepare and conduct a baseline survey with the Field Supervisors and Community Health Volunteers.
- b) Promote team work among the colleagues
- c) Coordinate the activities with other workers and agencies.
- d) Visit each field supervisors/MPHW at least once a week on fixed days; observe and guide them in the day-to-day activities.
- e) Arrange group meetings with leaders of community and involve them in spreading the message of various health programmes.

## SECTION V

### MANAGEMENT TRAINING AND SUPPORT

1. JOB DESCRIPTION
2. GENERAL PRINCIPLES OF TRAINING
3. GENERAL PRINCIPLES OF SUPERVISION
4. SELECTION TRAINING AND SUPPORT OF CHVs
5. MANAGEMENT AND MONITORING OF PRIMARY HEALTH CARE





- f) Scrutinise the maintenance of records of the field supervisors/MPHWs to guide them in their proper maintenance.
- g) Conduct regular staff meetings for the field supervisors/MPHWs and community health volunteers.
- h) Attend staff meetings at sub-centre/hospital.
- i) Participate in mass camps and campaigns in health programme.
- J) Indent, procure and supply material to field supervisors/MPHWs.
- k) Supply of equipment & maintenance of subcentre.

#### 5. Records and Reports:

- a) Prepare, maintain and utilise prescribed records and reports.
- b) Review and consolidate periodical reports. Submit reports through the Medical Superintendent to CMAI, Area Office & Community Health Department.

#### 6. Others:

- a) Respond to urgent calls from the Field Supervisor and CHVs and render necessary help.
- b) Organise and utilize the youth club, village committee etc in the family welfare programmes.
- c) Personally motivate resistant cases for family planning.
- d) Be alert to the sudden outbreak of measles, cholera, pertussis, malaria and take all remedical measures.
- e) Help the community in the construction of soakage and manure - pits and sanitary latrines, etc.
- f) Prepare charts, maps of the area and statistics and display at subcentre/hospital.
- g) Select Field Supervisor in consultation with the Chief Executive Officer of the Institution.
- h) Attend the relevant training programme related to microproject management organised by CMAI.
- i) Select CHV in consultation with Field Supervisors and Village leaders.
- j) Accompany the Project Development Officers or other CMAI Staff during the site visit.

## Summary:

At the institution level the Project Manager is the person who is fully responsible for the management of the CBPHC project. He will supervise and guide the Field Supervisors and Community Health Volunteers in their work. He will report to the Chief Executive Officer of the institution.

## JOB FUNCTIONS OF THE FIELD SUPERVISOR/MULTIPURPOSE HEALTH WORKER

### Introduction:

The FS/MPHW should be a full-time staff of the project. It is preferable that this individual has some experience of health work at field level and also has some basic nursing skills. He/She will be responsible to the Project Manager.

### I. REGISTRATION

1. She will register: (a) pregnant women from three months of pregnancy onwards, (b) married women in the reproductive period, (c) under two years children through systematic home-visits and at clinics.
2. Maintain maternity record, register of antenatal cases, eligible couple register, children register up-to-date.
3. Categorize the eligible couples according to the number of children and age of mothers.

### II. CARE AT HOME

1. She will provide care to pregnant women especially registered mothers, throughout the period of pregnancy.
2. Give advice on nutrition to expectant and nursing mothers.
3. Distribute iron and folic acid tablets to pregnant women, and Vit. 'A' solution to children.
4. Immunize pregnant mothers with tetanus toxoid.
5. Refer cases of abnormal pregnancy and cases with medical and gynaecology problems to sub-centre or referral hospital.
6. Conduct deliveries in her area.
7. Supervise deliveries conducted by dais and wherever called in.
8. Refer cases of difficult labour and new borns with abnormalities and help them to get institutional care and provide follow-up care to patients referred to or discharged from hospital.



9. Provide atleast three post-delivery visits for each delivery case and render advice regarding breast feeding.
10. Spread the message of family planning to the couples: motivate them for family planning individually and in groups.
11. Distributes conventional contraceptives to the couples, provide facilities and help to prospective adopters in getting family planning services, if necessary, by accompanying or arranging a CHV to accompany them to the referral hospital.
12. Provide follow-up services to family planning acceptors, identify side-effects, give appropriate advice and refer those cases that need attention by physicians to the subcentre/referral hospital.
13. Assess the growth and development of the infant and take necessary action by regular weighing of under two children at subcentre and at home.
14. Do BCG, DPT and Polio, measles (if available) vaccinations at subcentre.
15. Provide treatment for minor ailments, provide first aid in case of emergencies and refer cases beyond her competence to the referral hospital.
16. Notify notifiable diseases which she comes accross during her visits. (all infectious diseases including TB and leprosy).
17. Record and report births and deaths occurring in her area to the Project Manager.
18. Record infant deaths and deaths and then causes & report to PM

### III. CARE AT THE SUB CENTRE

1. Arrange and help M.O. and Project Managers in conducting MCH. Clinics at the sub-centre.
2. Conduct urine examination and estimate Hb% at subcentre.
3. Educate mothers individually and in groups in better family health including MCH and family health, FIONA, nutrition, immunization, oral rehydration theory, Vit A, hygiene and minor ailments.

### IV. CARE IN THE COMMUNITY

1. She will identify women leaders and help them to organise meetings.
2. Participate in Mahila Mandal meetings, and utilise such gatherings for educating women in family welfare programmes.
3. Utilise satisfied customers, village leaders, dais and others for promoting family welfare programmes.

## V. OTHERS

1. Maintain the cleanliness of the centre.
2. Attend staff meetings at subcentre and at hospital.
3. List dais in her area and involve them in promoting family welfare work.
4. Help the Project Manager in the training programmes of CHVs.
5. Coordinate her activities with community health volunteers and other Field Supervisors.
6. Prepare and maintain all registers and records, and maps, charts, for her area in the sub centres and submit the prescribed periodical reports in time to the Project Manager as per standing orders or instructions.
7. Conduct a baseline survey along with the PM and CHVs.
8. Strengthen the knowledge of CHVs on FIONA.
9. Attend the relevant and necessary training programmes related to microprojects when

## JOB FUNCTIONS OF COMMUNITY HEALTH VOLUNTEER:

1. Will be responsible to Project Manager through Field Supervisor.
2. Conduct survey for registration of fertile couples and provide family planning information and education.
3. Distribute contraceptives to the clients and make regular follow-up visit of contraceptive clients.
4. Refer individuals to nearest health centre for sterilization and IUD who request these services.
5. Identify married woman of reproductive age group, U/2 children and women or family, practicing family planning. Keep daily record of activities, and submit activity report to supervisor indicating number of clients served.
6. Educate the women in the village on the vaccine preventable diseases.
7. Motivate the mothers having under 2 children to bring them for vaccination against vaccine preventable diseases of children to the subcentre.
8. Educate the women on diet, and importance of antenatal checkup and motivate them to get regular antenatal care at subcentre.
9. Report the number of pregnant women in the area to the F.S.

10. Educate the women on diarrhoeal disease and importance of oral rehydration therapy.
11. Organise and conduct ORS preparation demonstration sessions to women in her area.
12. Educate the women about nutrition for the children and stress on the importance of breast feeding.
13. Educate women on preventable blindness of children and on sources of Vit-A in the food.
14. Report to the F.S. the number of children who had suffered from diarrhoea, and vaccine preventable diseases, the care given and the outcome.
15. Help the P.M. and the F.S. to conduct the baseline survey.



## GENERAL PRINCIPLES OF TRAINING

### BASICS OF BEING A GOOD TEACHER

The Mediocre Teacher Tells The Good Teacher Explains The Superior Teacher Demonstrates The Great Teacher Inspires
--

The teacher's main responsibility is

- 1) to decide what the student should learn
- 2) make sure that the student learns it.

1. Deciding what the student should learn - this is the course CONTENT

1.1 Begin by looking at the job description i.e. what specific tasks are expected of the student at the end of the course thus if a CHV is to bring children for immunization it follows that the course content must include the topic of immunization.

1.2 Having looked at the job description, the teacher must make decisions about

- \* which facts are important
- \* how much detail should the students learn
- \* what standard of performance is required

Taking the same example one of the tasks in the job description of a community level worker is to bring children for immunization.

For this the CHV must know :

- \* facts about immunizations such as the fact that vaccines protect against diseases, facts about the schedule of immunizations, facts about the vaccine reactions, etc.

- \* details - the teacher will have to make a decision on how much detail to give, i.e. should he/she talk about vaccines to prevent hepatitis? or should the more rare reactions like hypersensitivity to the vaccine be taught?

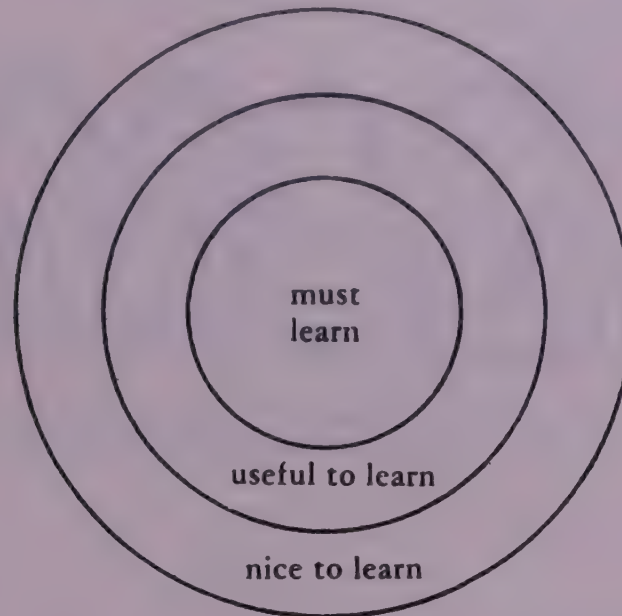
(Hepatitis Vaccine exists but is not available in India at present therefore this knowledge is of no practical value to the student.)

THE PRINCIPLE IS TO GIVE ALL THE INFORMATION THAT IS NECESSARY TO DO THE JOB, NOT NECESSARILY ALL THE INFORMATION THAT IS AVAILABLE ON THE SUBJECT.

Another way of saying this is:

- certain things must be learned
- certain things are useful to learn
- certain things are nice to learn

as summarised in this diagram



Must learn is a target - these are the things which the student must learn if he is to be competent in his job. These are the points which the teacher must stress while teaching. These are the points which must be tested in exams.

Surrounding the must learn target are many other things which are useful to learn but are not essential for job competency.

Nice to learn are other "facts" which may be of only theoretical importance, facts not relevant in performing the job.

- \* standard of performance, i.e. knowledge given should result in the desired effect; so it is important not only to teach relevant facts in sufficient detail but also to teach certain communication skills necessary for the CHV to achieve the desired result - in this case for all children to be immunized.

## 2. Making sure the student learns

Important principles in making sure of this are:

- 2.1 Clarity
- 2.2. Variety
- 2.3 Being sensitive to the varying abilities of your students
- 2.4 Assessment
- 2.5 Continuing self education

## 2.1 Clarity

Make sure that your students can hear what you say and can read what you write, also use simple language - avoid technical words that have no meaning for your students, e.g. instead of saying "apply digital pressure" say press with your finger.



The students may be able to hear the words you say but they may not really understand them.

## 2.2. Variety

Variety makes learning interesting, more importantly differing methods are suited to differing learning abilities - a good maximum is 'hear and forget .... see and remember .... do and understood'



"Hear and forget ..."

- a. Lectures - use this method to minimally; always try and supplement your lecture with appropriate visual aids such as :

Posters, flashcards, overhead projectors, slides, filmstrips, films, demonstration - make sure all students can see, this is especially true for demonstration



"The demonstration must be visible ..."



- b. Roleplay- in this method students act different parts as if they were in a play. Roleplaying exercises are useful in teaching students to experience themselves the feeling of others and also help in learning communication skills.

**Example:**

Ask student A to act the role of a health worker trying to persuade a mother to have her baby immunized against polio.

Ask student B to act the role of the mother. Explain that the mother is worried because she has heard that the immunization is dangerous and that her mother does not believe immunization is necessary. However, she must be persuaded although she respects her own mother.

Ask student C to act the role of the grandmother. The grandmother expects her opinion to be followed. None of her babies were immunized and all of them grew up to be strong and healthy. She believes immunization is unnecessary and dangerous.

Now tell the role players that the health worker is talking to the mother and grandmother in the health centre. Ask the role-players to act the parts you have given them by talking and reacting in the way they think that the mother, grandmother and health worker would behave.

Ask the other students in the group to watch and listen to what happens. They should note down things which the health worker does well and also the mistakes he or she makes.

They should think how they would have talked or acted differently. What other information would they have used? Would their manner have been different.?

Probably the role-playing will last for only a few minutes. Now comes the very important stage - the discussion.

Ask various students how they would have behaved and invite discussion from the group as a whole about the way the health worker behaved. Ask them also how the grandmother and mother felt. Would the mother have felt bullied? As the teacher you should try to start the students thinking about the emotions of the people in the role-playing. The students should also be made aware that facts are not enough for good communication.

- (c) Dramas and or songs are useful means of helping a Community to understand a particular health message and because it is a depiction of a real a situation in an acceptable manner, it is one of the methods which is more likely to assist in change of attitudes leading on to a desirable change in behaviour eg. accepting treatment for tuberculosis or accepting a contraceptive method, etc.

It is impractical to use a drama in a class room setting for teaching health professionals, but the CHV can use this tool for effective communication at community level.



- (d) Group discussion and debates





Much can be learned by exchanging ideas they have on a topic, especially so if they have some work experience in the health field. Remember when teaching women who are mothers, all of them have some experience in child rearing; stimulating students to share their experiences and debating differing opinions is a useful way of initiating "active" learning.

- (e) Learning through games: Games with a health perspective can be designed, e.g. "The Health Race" - a modification of snakes and ladders, where, on reaching positive health practices the player is given a boost and on reaching negative practises brought to a lower number.

"Eliminate the Disease"- is a game in which cans with the names DPT & OPV are hung by a string. The player using a catapult is expected to eliminate the diseases. He is given 5 shots signifying 3 primary + 2 booster doses necessary for complete protection.

### 3. Being sensitive to the varying abilities of your students

Students have different rates of learning, different experiences and abilities. Get to know each student, allow enough time for each student to understand the main points of their lessons. Varied teaching methods will be helpful in assuring that most if not all your students learn.

### 4. Assessment - make sure you allow adequate time for assessment

The purpose is to :

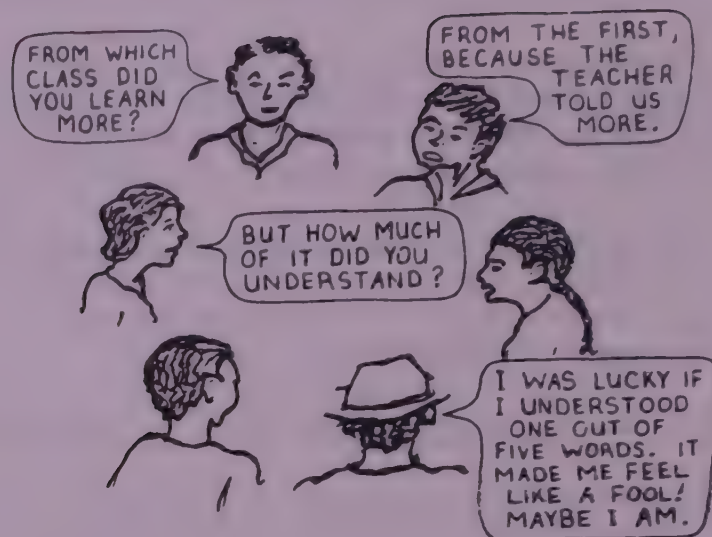
- a. determine how much of the lesson the student has grasped
- b. use the results of such an assessment to modify your teaching methods.

\* simple ways of assessment are

- allow sufficient time for questions and answers at the close of each session.
- where communication skills are necessary for job competency the student may be asked to role play : the group can participate in constructive criticism of the role play.
- questionnaires or tests to assess knowledge gained by the students. Pre and post, questionnaires have an added advantage that results can be used to modify teaching methodology where appropriate.



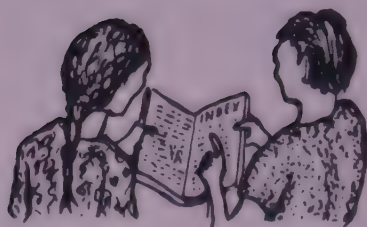
- feed back from student regarding



course content  
 method of teaching  
 quality of handouts,  
 slides-clear or confusing  
 suggestion for improvement  
 use this feedback to make modification where appropriate.

The focus of health worker training has been changing:

from memorizing facts . . . . . to . . . mastering specific skills  
 from studying about problems . . . to . . . practice solving real problems  
 from classroom learning . . . . . to . . . field and village experience



# Continuing self education -

Involvement in personal learning is a necessary condition for being an effective teacher.

This involves :

- a. keeping up with developments in the subject matter being taught by reading relevant publications, manuals, text books etc.
- b. attending seminars workshops, in your subject and related areas modifying your teaching to emphasise present conditions.
- c. it is essential to know the manner in which health care is provided. Familiarize yourself with national health policy, with government health care delivery personnel and facilities in your area.

BE A CONTINUOUS LEARNER YOURSELF. ACKNOWLEDGE GAPS IN YOUR KNOWLEDGE BELIEVE THAT YOU CAN ALWAYS LEARN MORE.



The best student and health worker is not the one who has the best memory. He is the one who takes the time to look things up

#### PLANNING AND ORGANIZING VILLAGE LEVEL TRAINING

All field workers (PM & FS) have to plan, prepare and organize training of CHVs as part of their ongoing project work. Since training forms a part of various projects/activities, the subject is of key importance.

##### A. KINDS OF TRAINING FIELD WORKERS MAY HAVE TO PLAN AND ORGANIZE

1. Training based on health needs of the community, Specific skills relevant to health and development.
  1. Conducting health education on family planning
  2. Demonstration on ORS preparation
  3. Organising immunization of mothers and children
  4. How to build a pit latrine
  5. Record keeping

As a Project Manager you will be assisting in organising the above training and may be requesting people from outside who have specialized knowledge of the subject to conduct training.

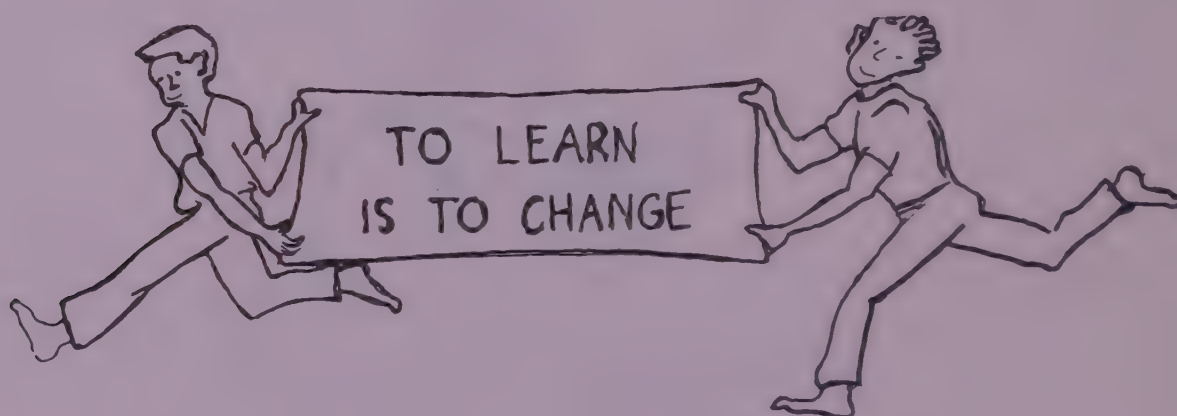
## 2. Informal training by field workers

Sometimes you will be informally training field workers yourself. This could be on a one-to-one basis, or when you visit the village or sub-centre.

## 3. Existing training programmes in which Field Workers can participate

Several agencies and organizations are carrying out training programmes. The best way to get this information is from the District Offices and the BDO. Find out what is being offered, when, and for whom?

Besides organizing training, you can send trainees to programmes that are appropriate for them.



### CAUTION!

#### When sending CHVs to existing training programmes.

- \* Do not send them to existing training programmes just because the training is available.
- \* Make sure there is a real need in an income project, or a community development project for the specific training you select. Make sure the appropriate person is sent, e.g. pig raising in a predominantly Muslim community.
- \* Trainee/trainees on return to the community should be provided with the opportunity to put the training to use, e.g., if you are sending someone to learn how to make sweaters on a machine, on return from the training the person will need to have -
  - the machine
  - knitting wool
  - space to work
  - etc...



Therefore, plan ahead for these items. Otherwise the person is frustrated, and the training is wasted.

## B. PLANNING THE TRAINING

### Points to consider

How you plan a training programme can greatly affect the way the training is done, and the kind of learning that will take place. You may or may not have organized several training activities for CHVs. As you know there are many approaches to training. There are, however, a few points of key importance that can help make training programmes useful and effective.

Training to be effective must be:

- \* based on the needs of the trainees and have their participation in all aspects as far as possible.
- \* related to the project or activity that is to be implemented, and not just done for the sake of 'training'
- \* practical and field-oriented - connected with the day to day life of the community
- \* a way of providing an opportunity for the community to develop problem-solving skills and confidence.
- \* follow up regularly

Too often training programmes are planned without sufficient thought being given to the above points. The time and place is fixed, instructor chosen, content decided without any consultation with the trainees. The methods of training (mostly lectures) often are unsuitable to the needs of the CHVs. The training, therefore, though conducted according to plans, is not really useful to the communities.

### WHO PLANS?

The Project Managers and Field Supervisors are responsible for planning and organizing the training of CHVs. This does not mean you must work alone. You can form a group/committee and request 2-3 members to work with you as a 'training team', or if this is not possible, you can request their help informally. It is a way to involve the hospital in planning training activities with you.

### PLAN CAREFULLY

The training is for a day, two days, a week, you still need to plan it out carefully so that trainees can obtain the maximum benefits.

The following steps help you in planning and conducting a training, and important points you need to consider in doing so.

## COMMUNITY LEVEL TRAINING

1. Identify type of training required

2. Select trainees

3. Assess trainee needs

4. Develop a training plan

- \* Objective of training
- \* Location
- \* Duration
- \* Content
- \* Training methods
- \* Selection of resource persons
- \* Funds and resources
- \* Field work plan
- \* Plan for evaluation
- \* Follow up plan

5. Carry out training plan activities

6. Conduct the training

7. Evaluate and review training

1. Identify clearly the kind/type of training required through :

### \* Observation during visits

- When you visit household/families, or groups, observe the things which could be improved by training e.g. you may observe that children are dirty and not well looked after, (training for mothers in proper child care is required) or
- if you see a child with paralysis - education regarding immunization is required.

### \* The Project plan

- Community Based Primary Health Care Project has certain activities for which specific training is required.

Decide together with your group/committee/training team which training is needed most and what should be done most, and what should be done first.

2. SELECT TRAINEES

Refer to chapter on selection of CHVs.

3. ASSESS TRAINEE NEEDS

## THIS STEP IS VERY IMPORTANT

- \* Through informal discussion with trainees, after selecting trainees, and before making any detailed program, you must meet and talk to half of the selected trainees to find out what their ideas and views are regarding the training, and their special needs.

Find out

- What they already know about the subject selected for the training.
- What skills they have, what are some of the things they can do well.
- What are the most important topics about which they need to learn more, and what other skills are required.
- Their ideas for training in general

- \* Also assess the training needs based on job description (if this is applicable - what knowledge and skills trainees will require to carry out their responsibilities effectively.

The information you gather at this point will help you plan and :

- Set clear objectives for the training programme and develop a relevant curriculum (content of training)
- Will give you a rough idea of the level of skills and knowledge that trainees already have
- Include other ideas of trainees in the plan

### 4. DRAW UP A SIMPLE AND TENTATIVE TRAINING PLAN

The plan will guide you in preparing the training programme, and gives you an idea of what things to consider.

(You can change and modify this plan as you make preparation for the training)

The plan should include: -

(a) Objective of the training programme

Write this as end results of the training and state them clearly.

(b) Location/place

- where will the training be held:  
house/school/panchayat office
- will accommodation be required for trainees or Resource persons?



(c) Duration

- how long will the training last - one day, 3 days a week, etc...?
- also suggest the time of year that is most suitable to the CHVs as well as the resource persons/trainers who will participate.

(d) Content of the training (curriculum)

- list here tentatively the topics to be included as identified by the trainees, (when doing trainee needs assesment).
- add to this list from your observation and understanding other subjects that are necessary, particularly those related to the project which will be implemented.
- the detailed content of the training will have to be decided together with the resource persons.

(e) Training methods

Give thought to the way in which training will be conducted:

To encourage trainees to learn and participate, emphasise the use of methods that promote this.

Example:-

- group discussions where everyone takes part.



- individual assignments, to encourage individual responsibility.

Stimulate problem solving by CHVs, and encourage them to think out the causes of problems.

- participation of trainees in planning some of the sessions and activities.
- visits to successful projects that are similar to the one you are training for. Observation and discussions with people involved in the projects can help trainees gain first-hand knowledge of what is possible and the problems they can run into.

- role play, if suitable and can be grasped by CHVs.
- demonstrations, e.g. preparing a nutritious meal for the family, planting a vegetable garden, etc.
- use of training aids/materials where necessary

#### (f) Selection of resource persons/trainers

Depending on the content of the training, you may want to select appropriate resource persons to carry out the training.

- are there experienced people within the community who can assist in the training?
- which resource persons will you need from outside?

In selecting resource persons, try to involve those who,

- have an understanding of village communities and treat people as equals, and with respect.
- speak the same language as the CHVs.
- are competent and knowledgeable about their specific topic and have the ability to communicate it in a practical way.
- have had experience in training and working with CHVs.

#### (g) Orientation of resource persons

- Plan to meet with them. Orient/brief them about the training programme objectives and the tentative content, the back ground of trainees, and the training methods you wish to emphasise.
- You will have to work closely with the Resource Persons to develop the detailed content of each topic, and prepare simple training materials required for that particular topic.

Work with resource persons to prepare a lesson plan

#### WHAT A LESSON PLAN SHOULD INCLUDE

1. TOPIC
2. OBJECTIVES of training session
- 3 CONTENT of topic (break down topic into sub-points)
4. PLAN FOR session (include activities, discussions presentations, group work etc.)

(What Trainee will Do)

(What Resource Person will Do)



5. DURATION (time needed in classroom and field)

6. MATERIALS REQUIRED (posters, flip charts, worksheets, handouts, other audio visual aids)

7. FIELD WORK/PRACTICAL WORK - if appropriate

8. EVALUATION OF SESSION

(h) Funds and resources

- are these available as part of the programme you are associated with ?
- will the community contribute money or provide facilities for the training ?
- what outside assistance is required ?

(i) Plan field work and practical work

Field work must be planned in connection with class work. Try to relate the two. If you are going on a field trip, e.g. visit to a successful group project, make sure you arrange this beforehand. Talk to the person concerned about the day and time of your visit, what you hope trainees will gain from this visit. Observe the project yourself to see if it provides an adequate learning opportunity.

On the other hand, let trainees know the purpose of the field visit schedule. Assign them tasks so that they focus their observations & discussions and make it a real learning experience.

(j) Evaluation of training

Plan how you will evaluate the training, e.g.

- daily feed-back from trainees regarding each topic covered in the training, to assess what they have learnt.
- at the end of the training, an evaluation of the total training can be done by trainees, resource persons training team, and the others involved. (this could be done through informal discussions)

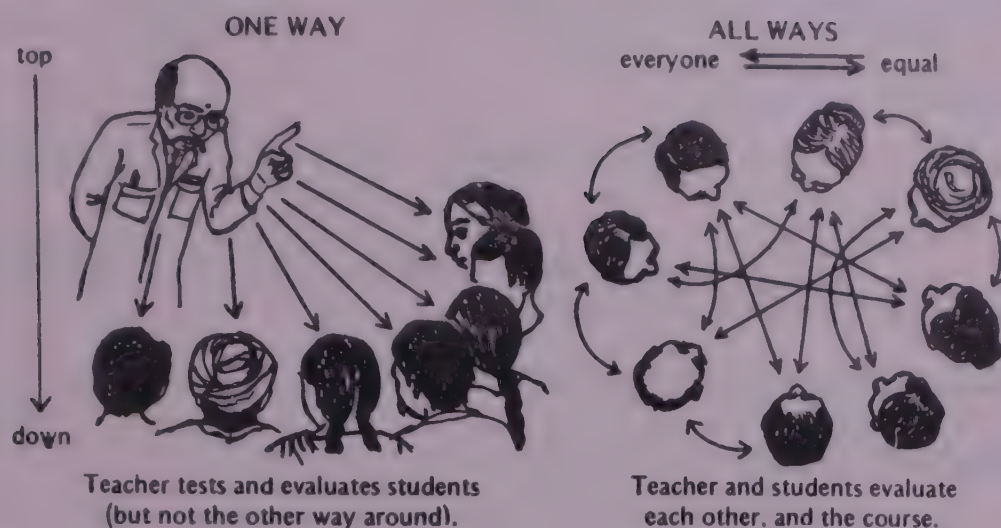
\* EVALUATION

What to evaluate ?

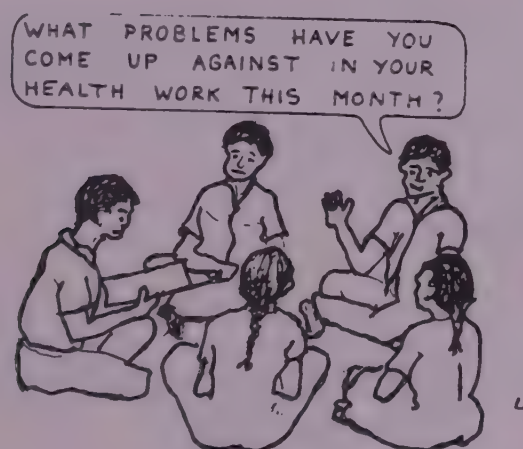
- the training content both of the class work and the field work-what was learnt by the trainees.
- methods of training, and use of training materials.
- performance of resource persons.
- participation of trainees



- practical arrangements (food, accommodation, social activities, etc).
- others.



#### (k) Follow up of the training



- what kind of support or supervision will the trainees receive after the training ?
- will there be follow up refresher courses to provide an opportunity for continuing learning ?
- will you plan similar training with other groups ?

Having included all these points in the training plan, you know the things you have to do before and after training.

## 5. PREPARE CHECK LIST AND CARRY OUT TRAINING PLAN ACTIVITIES

### Things to be done

- list the things that have to be done
- contact resource people.
- assign responsibility to the 'training team' (if you have one) and yourself.
- set dates by which planning activities have to be completed so that training will go according to schedule.

## 6. HINTS- developing the curriculum and schedule

### \* Identify priority topics

Look at the list of topics that have to be included in the training, circle those that are priority topics.

### \* Allocate time for each topic

Consider how much time you need to allow for each area of study. Work this out with the resource persons responsible for the topics.

If your total training period is for a week, figure out how many hours will be required to cover each subject, within the total time you have. Naturally some topics will require less time than others depending on the importance and complexity.

### \* Balance the training programme



Balance discussion type sessions (class work) with practical field work, (learning by doing). Practical work has to be emphasized so that trainees can practice the skills they need to acquire. Be sure that what is taught in theory, is also dealt with in the field work of practical work.

Prepare a time table (e.g. for a training period of 3 days)

Plan your class work and practical work on a day to day basis.



- (i) Keep your schedule flexible so you can make necessary adjustments if necessary, and do not be afraid to change your plans.

When training takes place in a village, emergencies or new situations may arise, or they may have learning opportunities you had not even consider in your plan, which is valuable for the trainees. Take advantage of such situations. Be flexible.

(ii) How to plan the day

Generally speaking:-

- mornings are a good time for class work particularly in difficult topics that need concentration and thought. Everyone is fresh at this time.
- afternoons are good for active discussions of practical field work. However, this will again depend on the kind of field work planned. If a convenient time for field work with CHVs is in the morning after "dal bhat", then you need to schedule accordingly.
- some evenings can be scheduled for a few social activities to break the routine, and provide an opportunity for resource persons and trainees to know each other better.

(iii) In the first day of the training, schedule activities that will enable the trainees to get to know each other, share their background and experiences. This time is not wasted, it leads to a more open exchange of ideas and livelier discussions, because people start becoming, familiar with one another.

(iv) Provide breaks in between the morning and afternoon activities.

(v) Do not wait too long to begin field work. Schedule it fairly early in the week.

(vi) Include sufficient time each day for review sessions. These sessions are valuable. Trainees have an opportunity in these sessions to say what was accomplished during the day, what they learn and what problems they had.

7. CONDUCTING THE TRAINING AND GETTING OFF TO A GOOD START

The first days of a training programme are often the most difficult. Have as much as possible ready ahead of time, and be prepared,

- practical arrangements for food and accommodation.
- training hall with adequate seating and light
- black boards, chalks, pencils, training aids, tools other supplies/material necessary.
- extra copies of the time table
- be sure to remind the resource persons of their sessions



- explain the schedule and plan of training to trainees. Let them ask questions to clarify these points.
- be sensitive to the trainees, note how well they are participating or if some are silent. Encourage the quiet ones.
- get daily feedback from trainees as planned in the evaluation. If trainees suggest certain changes, be open about including their ideas.
- summarize at the end of the day what took place, and outline what will be done on the following day.

## 8. SOME SIMPLE TRAINING AIDS AND METHODS

Simple visual aids can be very useful in conducting training, and communicating ideas, particularly in rural areas where the majority of the people are illiterate. Most villagers like visuals because they add attraction to whatever topic is being discussed. It is also easier to get a discussion started if you have a visual.

### **GUIDELINES IN VISUAL AIDS**

1. When using any training aids be cleared about :

- the purpose
- the idea to be presented
- your audience

2. Make your own training aids, using low cost materials.

3. See if you can get some one in the community e.g. a local artist to help you draw the pictures (in case you feel you are not good at drawings).

4. Keep training aids simple.

5. Find out what training aids already exist, and use them if appropriate.

6. Visuals are a tool to assist you in training and not an end in themselves. Visuals alone do not solve any problem, they have a limited effect on changing people's attitude and behaviour.

7. Visuals to be effective must be explained properly. (but don't lecture) Involve people in a discussion. Explain symbols. If using a series of pictures make sure CHVs are understanding them in the right order. Try to connect pictures with examples of their real life situations.

8. Practice the use of training aids before you actually used them in the community. This will give you confidence when carrying out the training.

### Points to consider when preparing visuals

- The drawing used in visuals should be relevant and familiar to the local community.
- The figures should not be overcrowded by the lot of background and other unrelated figures, otherwise it complicates and confuses what you are trying to explain.

- The visual aids made for the purpose of training should be previously tested in the village. Do not be afraid of changing the idea or the drawings, if they are not understood. If people donot understand the drawings you cannot really use the visual effectively.
- Use simple drawings.
- Use right proportions when drawing figures.
- Use appropriate colours according to the traditions of people e.g.: red, pink or light colours stand for happiness, and are colours used for women. Yellow is a colour used for God and Goddess. Black, dark and grey are considered negative colours.

Described briefly below are a few common visual aids that you can use while training e.g.:-

- Flannelgraph
- Posters
- Flip charts

#### FLANNEL GRAPH

A flannelgraph consists of a big piece of flannel material, e.g. one meter long, that is stretched over a display board or frame. Some sort of stand to hold it up (even a chair will do) or a stand made by tying sticks together is all right to use. If you cannot get a frame or stand hang the flannel from a wall.

Pictures need to be made, cut, and then sand-paper is glued on the back of pictures so they stick to the flannel.

#### HOW TO USE

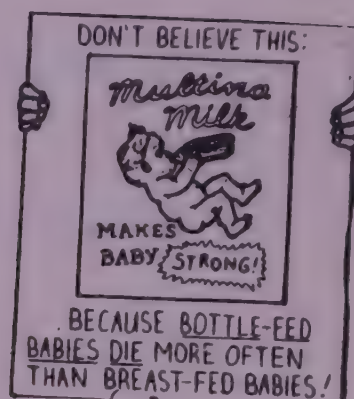
The flannelgraph can be used in group discussions to explain an idea through the use of pictures, or tell a story. You can involve the audience in telling the story. It is flexible. The figures you make can be used for explaining different subjects, and can be used over and over again. Use the flannelgraph with small groups.





## POSTERS

You can make colourful posters with large pictures to get particular points across to the audience.



### How to Use?

Use it during your discussions.

Post at key (well used) places in the village if you wish to use it for extension purposes.

- keep the poster simple, quickly understandable and easily visible.
- a poster attracts attention and interest.

## FLIP CHART

This is a very effective training aid if used appropriately. It consists of a series of pictures arranged in sequence to explain an idea, tell a story, teach step by step, and to have a group discussion usually to encourage some action.

- plan what you want to explain
- prepare the pictures you need
- arrange them in the sequence required.
- to keep pictures together you can staple, or glue them together.

### How to Use?

1. A flip chart can be used with small groups (upto ten) or with individuals. Depending on the size of the Flip chart you can use it with larger groups, but smaller groups are better for discussion purposes.
2. Even better than explaining the pictures to the audience, let them tell you what is happening in the picture.



## DEMONSTRATION

This is another training aid, where people learn by seeing. If people see a demonstration about how to make 'ausadhi pani' (rehydration solution) they will be much more likely to understand the process, especially if you have one of the CHVs help with the demonstration you can reinforce the demonstration by using a visual at the same time.

Other demonstrations to train people may require, e.g. looms for weaving, machinery and tools. Try to assemble some of this equipment for your training if possible. Demonstration on 'how to do' should generally be included in the lesson plan.

## OTHER TRAINING AIDS:-

- \* Handouts
- \* Flash cards
- \* Puppets
- \* Role play
- \* Drama
- \* Songs

Finally consider your approach and attitude when carrying out training.

IT IS NOT ONLY WHAT YOU TEACH THAT COUNTS, BUT THE WAY YOU TEACH THAT CAN BUILD PEOPLE'S CONFIDENCE OR BREAK IT DOWN.

## Suggestions to Trainers:

- \* Learn about the persons you wish to teach.
- \* Find out what the persons already know, what their experience are.
- \* Make them feel confident about what they already know.
- \* When explaining ideas, use simple words that trainees understand.
- \* Build on what they already know and do, and suggest additional ideas.
- \* Find out if these ideas are applicable to the trainees situation.
- \* If necessary, demonstrate what you mean.
- \* If you do not have all the answers to their problems, say so, but try and find someone who can be of assistance to them.
- \* Concentrate on one issue at a time
  - eg. do not teach community organisation and ORT at the same time.

Source: Manual for field workers - UNICEF, Nepal.

FOR FURTHER READING: HELPING HEALTH WORKER'S LEARN - DAVID WERNER.

## GENERAL PRINCIPLES OF SUPERVISION AND TEAM WORK

1. What is a supervisor?: A supervisor is responsible for seeing that other's work is done correctly. So he must work with and through people to get the job done.

A supervisor has subordinates for whom he is responsible but he also has superiors. As he works he must learn to balance the expectations of his subordinates and his superiors. This will occasionally cause some stress.

As a PM you will be responsible for managing the CHPHC's programme within the organizational structure of your hospital. You will need the guidance and support of the hospital staff. Therefore it is in your interest to establish good rapport with them.

How to establish rapport with hospital staff?

1. Involve them in your planning process
2. Seek their guidance for implementation at all levels eg. training of CHVs.
3. Invite them for any meetings arranged in the community.

REMEMBER THAT BACK UP SERVICES AVAILABLE AT THE HOSPITAL ARE ESSENTIAL FOR YOUR PROGRAMME.

IF YOU CANNOT TOLERATE A CERTAIN AMOUNT OF STRESS YOU WILL PROBABLY NOT ENJOY BEING A SUPERVISOR.

WHY IS SUPERVISION IMPORTANT?

The effectiveness of workers depends on the supervision they receive. Even well trained highly motivated workers become discouraged and ineffective when supervision is lacking.

## 2. USING DIFFERENT STYLES OF SUPERVISION

There are three main styles of supervision: autocratic, anarchic and democratic.

You have probably met supervisors who were very dictatorial, who may have said, "Do what you are told, and don't ask questions!". They practise an autocratic style of supervision. The health workers have no choices to make and no influence on the type of work that is done. You may have met supervisors who in effect say, "I don't care what you do, as long as you keep out of my way!". This style of supervision can be called anarchic. The workers have complete freedom of choice and can do as they like. You may have been fortunate enough to have worked with a supervisor who said to you. "These are the results we have to achieve; this is the job to be done. Let us agree together how best to do it!". This supervisor practises in a democratic or consultative way.



Autocratic - Do what I say! Anarchic - Do what you like!



Democratic - Let us agree on what we are to do.



Consultation on work programme.

On the whole, democratic supervision helps people to grow, to become responsible for their own work, and to take initiative. People like to be consulted. However, instructions must be carried out. Instructions must not become subject to discussion.

### Deciding how to supervise

Most people prefer to work under a democratic leadership. However, this does not mean that the democratic style is always best. The choice of style of supervision depends on the kind of work to be done (job factors) and the kind of people to be supervised (personal factors).

Job factors include:

- the complexity of the job
- the difficulty of the job
- the need for quick decisions
- the need for consistent results, and



- the need for creative work (new ideas).

Personal factors include:

- the skill, reliability and experience of those who do the work, and
- their willingness to accept responsibility and to make decisions.

Note: Usually autocratic supervision succeeds only when subordinates can be closely supervised and controlled. In rural health work close supervision of the staff of an isolated health post is difficult and autocratic supervision is therefore not suitable normally.

What style should the supervisor adopt? It should not be one that only suits his personality and not the circumstances and needs of the job and the abilities of the workers.

### CASE STUDY I

In 1981, Joe was appointed Programme Manager in a rural area. He moved there with his family. The local housing and school were poor. Joe was responsible for supervising the field supervisors in his programme. Communication and transportation among the sub centres was a constant problem.

The field supervisors had poor morale. One of them was very bossy. Another lived alone. Very often she left to visit her family in the city. Field supervisors did very little work.

Joe tried to keep everyone happy and avoid conflict as much as possible. He did not receive any co-operation. As a result, he could not do much of the work expected of him.

What is style of this supervisor?

Is it effective?

What style should this supervisor use?

### CASE STUDY II.

Rajan has just completed a course in supervision and has been posted to Alepata District where he will supervise two field supervisors. Rajan is a social worker. He has worked in the city and has not much experience in rural areas. However, he wants to do a good job and is willing to work hard.

Sina has been a A.N.M. in the Alepata District for three years. She comes from the area and knows everyone. People respect her. She works hard and knows her job. She has been running a health center with almost no supervision and doing a good job of it. Now Rajan is her supervisor.

Rajan thinks he must take control from the beginning. He thinks Sina will not respect her. He has just told Sina exactly what he wants her to do at the health centre. He gave her a weekly work schedule and told her should be

used by health centres in the area. Rajan told Sina that she must follow the schedule. Sina did not say anything, but after the meeting she did not seem friendly. Rajan wonders why.

What leadership style did Rajan use?

What style should he use?

What will happen if he does not change his style?

What style should the supervisor adopt? It should not be one that only suits his personality and not the circumstances and needs of the job and the abilities of the workers.

### 3. Team Building

As a Programme Manager you will have to work with others to achieve a common goal. Your goal and the goal of your co-workers to promote better health in your programme area.

A group of people does not automatically co-operate and work together towards a common goal. Someone must make the group into a team.

(i) Listen to your Field-Supervisors and CHVs. Remember that they probably have more experience in implementing health activities than you do at this point.

(ii) Set goals with co-workers:

Each activity relating to child survival has a specified target population and specified performance expected. Share these expected performances with your co-workers at the start of the programme.

(iii) Use meetings:

Brings all CHVs & FS together as a group to discuss and share their experiences use these meetings to emphasise the common goal you are all together working towards.

Exercises in team building:

(1) How you act in groups?

(2) Broken squares.

### 4. Communication skills:

(1) What is communication?

Communication is sharing information, ideas, or opinions with others. The important word is sharing. Communication is more than just giving instructions to others. It means mutual understanding between the sender and the receiver of a message.



Every communication has three parts:

The message

The person who sends the message

The person who receives the message.



Communication is a supervisor's most important tool. It is essential to every other supervisory skill. Good communication improves teamwork.

Many supervisors think good communication means giving instructions and having people follow them. They receive instructions from their supervisors and are expected to understand and follow them. These supervisors say, "Some people order and others must obey!". Where have you seen this attitude before? It is associated with what kind of leadership style?.

## (2) ONE-WAY COMMUNICATION

One-way communication goes only from the sender to the receiver. In one-way communication, a speaker believes that what he says is right. He believes his way is the best to do things. He wants others to do what he says. This type of supervisor does not see any need for conversation or exchange of ideas with mid-level health workers.

One-way communication causes two main problems. First, the sender is never sure that the receiver understands the message. Second the receiver resents always being told what to do. Authoritarian supervisors use one-way communication much of the time. For example, an authoritarian supervisor wants a mid-level health worker to order drugs correctly. He thinks to himself: "These ordering instructions are so simple even a mid-level health worker can understand" In one-way communication, the supervisor seldom asks questions to see if the mid-level health worker really understands the message.

## (3) TWO-WAY COMMUNICATION

Two-way communication goes back and forth between the sender and the receiver. In two-way communication, the receiver of a message actively participates in the communication. He listens to the message, he asks questions to be sure he understands, and the added information is feedback. Feedback distinguishes one-way communication from two-way communication. Look at the diagram below.



Ask for Feedback



### Listen Actively:

Listen actively to ideas, comments, and suggestions from mid-level health workers. Try to understand their point of view.

### Understand others' moods:

Be aware of the mid-level health worker's moods and attitudes that may be affecting communication.



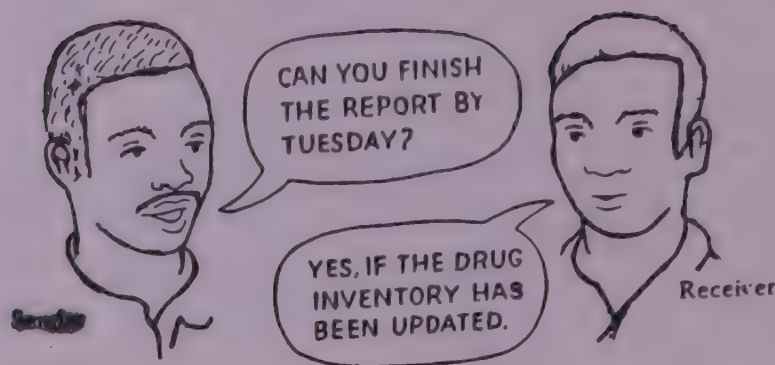
### Ask Questions:

Ask mid-level health workers questions to make sure they understand your message and that you understand their message.

## (4) PROBLEMS IN COMMUNICATION

Communication is not easy. It takes practice. You will encounter problems that interfere with your attempts to communicate with mid-level health workers. A few of these communication problems are described below:

## TWO-WAY COMMUNICATION



In two-way communication, the supervisor who is communicating respects the mid-level health worker's ideas. He wants feedback from the mid-level health worker. Two-way communication means that the sender and receiver work together to achieve understanding. It means an active role for the receiver, who has the responsibility to provide feedback to the sender. If the sender does not get good feedback, the two-way communication will not be effective.

The advantages of two-way communication are first, the sender can be sure that the receiver understood his message. Second, the receiver provides feedback. Expressing feedback makes the receiver feel his ideas and opinions are important. Participative supervisors use two-way communication most of the time. In fact, two-way communication is characteristic of a participative style, just as one-way communication is characteristic of an authoritarian style.

Two-way communication requires more time and effort, but it is much more effective. As a supervisor of mid-level health workers, you should use two-way communication. Use these guidelines to maintain two-way communication with mid-level health workers.

### Communicate Clearly:

Make your messages and conversations as clear and simple as possible. Communicate the important and essential information.

### Ask for Feedback:

Ask for ideas, comments, and suggestions from mid-level health workers. Insist on feedback in all communications.



### **Inaccurate or Incomplete Messages:**

Sometimes a message is confusing because the information is wrong or mixed up. Sometimes a sender uses words that are not understood by the receiver. For example, a supervisor might tell a mid-level health worker to give a certain patient medication three times a day. If he forgets to say morning noon, and night his message will be incomplete.

### **Age or Social Barriers:**

Two-way communication may be difficult when the sender and receiver have a very different status. For example, a mid-level health worker might hesitate to discuss his diagnosis with a very senior medical officer, or an older, experienced mid-level health worker might have trouble taking instructions from a young, newly-trained supervisor.

### **Filtering:**

People have biases. They see things from different points of view. Sometimes these biases, or filters, interfere with communication. Supervisors must be aware of their own biases and always try to see the other person's point of view. You do not have to agree with the other point of view, but you must at least understand it. For example, a supervisor might cancel a regularly scheduled visit to a remote health centre's mid-level health worker, who already feels isolated and neglected and could interpret the cancellation as another example of lack of support. This supervisor must understand the mid-level health worker's point of view, even though cancelling the visit was unavoidable.

### **Leaving someone out of a communication:**

Sometimes a person is left out of a discussion or a meeting that affects his work. He misses an important message, and his work suffers. For example, a supervisor might neglect to invite a mid-level health worker to a district meeting at which a new drug is introduced. The mid-level health worker in this case would not learn about the availability of the drug which could benefit people in his area.

### **Lack of Acceptance:**

Sometimes a person simply refuses to communicate. He hears only what he wants to hear. Perhaps he does not trust the sender, or he is in a bad mood. Perhaps he does not agree with the message. For example, a supervisor might tell a mid-level health worker, "From now on, immunize infants between four to six months of age." If the mid-level health worker walks away saying to himself, "That is not the way I was taught," he may continue with immunizations as before.

### **Inattention:**

Some people do not pay attention to messages. They do not read instructions carefully. They do not listen carefully.





### Poor Memory:

A person may communicate a message well, but the receiver may forget it.



### Information Overload:

When a person is given too much information, he may forget some of it. A supervisor who wants to communicate effectively must be careful to keep the message simple. Do not include unnecessary details that may confuse the person receiving the message, e.g. supervisors who write a letter inviting mid-level health workers to a special meeting at the district hospital also includes a long description of the new leave policy in the same letter. Some mid-level health workers might overlook the invitation to the meeting because they focus their attention on the new leave policy. This letter contains too much information.



(5) Controlling and Assessing work:

Once the duties of your health workers have been planned and activities clearly understood by them, control measures can be devised to see that the programmes proceeds as expected and to help the team to maintain the expected amount and quality of work.

For example:

- As PM you know there are 25 - 35 pregnant women in your area at any given time.
- Your aim is to provide antenatal care including tetanus toxoid to 80% of all pregnant women.
- You can make a quick assessment of performance of this activities by asking your FS, how many doses of tetanus toxoid she used in the past month.

Remember that performance assessments must be done regularly - there is no point in waiting to check performance till the time when reports have has to be submitted.

This kind of performance assessment can be done at monthly meetings where actual details of work accomplished are compiled. Deficiencies in the work can also be analysed and corrected at these meetings.

THE BEST SUPERVISOR PROVIDES SUPPORT  
WITHOUT TAKING CHARGE AND WITH SKILL,  
UNDERSTANDING AND PATIENCE

## SELECTION, TRAINING AND SUPPORT OF CHVS

Introduction: Forward by a Village Health worker, Lalanbai

My name is Lalan

People call me Lalanbai

Pimpalgaon is the village where I was born in a Harijan Family. I was married when I was 10 years old.

Our son was born when I was 15, but two years later, my husband put me out of his house.

My little son died when he was only five years and I was left with my father's family.

My father found another husband for me, but he died two years later, after my daughter's birth.

I refused to accept another husband, but I have lived in Pimpalgaon since then.

One day, the Sarpanch sent for me.

I was afraid he might be angry and I didn't want to go because my sari was torn.

To my surprise, he told me I was chosen to be trained as the Health Worker for the village.

How could I possibly accept? I was a Harijan widow, and illiterate, I think I was chosen because they knew I worked hard, and was not quarrelsome. And they knew I was honest. But I was very doubtful. With many misgivings, I agreed to try for a month and went to Jamkhed with another village Health Worker.

Trying to sit quietly and listen for the whole afternoon was very difficult. I became stiff and tired.

When I held the picture flashcards in my hands I was afraid. How could I ever learn to teach people with these?

After that first day, I lay down with a blanket over me and had high fever and chills. I was so frightened.

When the team from Jamkhed visited Pimpalgaon the next Monday. I dressed and went to meet them because I had promised.

They gave me medicine, but more than that, one nurse put her arm around my shoulders with love, and helped me gain faith in myself.

With the help of the Team, I began my work.



Slowly I began to feel more confident and to feel the urge to work for my people in the village.

Each day I gained more satisfaction.

The work has given me great rewards and peace.

I can visit anyone when there is illness in the family, or when they need help.

I have gained so much knowledge.

The mothers of children bless me, something money cannot buy.

I know now, that after I die the people of my village will say: "there was once a women named Lalanbai, a village health worker, who helped all of us in the village".

I have recently learned to read and to write, and I would like to share this message with women like myself.

## 2. Selection

- General considerations
- What kind of person to look for
- Process of selection
- Dangers involved in choosing a CHV

### 2.1 General considerations

- \* Selection does not need to have consent of the whole village (this is not possible) i.e. there is really no need to get the whole village to select a CHV by holding a village meeting. However it may be possible to form a small "Selection committee," consisting of members from the community.
- \* The person selected should be acceptable by the majority of people who also form the poorer groups in the village CHV MUST IDENTIFY WITH AND REPRESENT THE INTERESTS OF THE POOR IN THE VILLAGE.

### 2.2 What kind of person to look for?

One who has ROOTS in the village

One whom they TRUST

One to whom people GO when they have TROUBLES

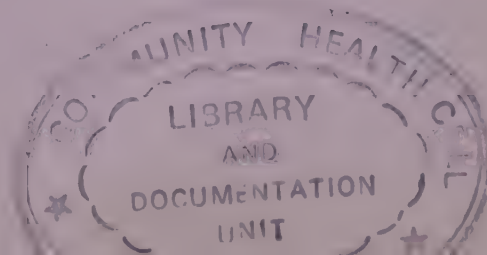
One in whose abilities they have CONFIDENCE

One who is WILLING TO SERVE and has RESPECT FOR PEOPLE

One who can LEARN AND WHO IS fairly open to CHANGE,

Usually, one who has had children of her own and experience in life.

One who has shown that she has managed her own difficulties adequately.



### 3 Process of Selection:

- preparing the community - The most effective Village health Workers seem to be those chosen "by the people". BUT BE CAREFUL OF THE PROCESS.

It is the responsibility of the Health Team or SOME other ANIMATOR to prepare the Village Community for making a choice. In our experience, usually a woman, acceptable to various groups within the village is chosen. (In tribal communities men have been proved to at least effective)

#### HOW DO WE GO ABOUT THIS?

(1) SPEND TIME chatting about it in various parts of the village, sharing with all that the choice is to be made by them.

(2) SHARE YOUR OWN EXPECTATIONS with the formal and informal leaders of all factions.

(3) Make it clear that she is part of the Health Team, paid MINIMALLY by the project and ACCOUNTABLE TO THE TEAM AND TO THE COMMUNITY for food, medicine and money.

(4) Make it known that she must have a fair amount of time to give in SERVICE of her people - emphasize her service role, de-emphasize the payment for service.

(5) Create UNDERSTANDING THAT SHE must be acceptable to all factions ONLY AFTER the Health Team feels assured of a good understanding of these factors are suggestions of names received and a choice made by the people.

- you can be a part of this PROCESS by Sharing and Listening especially for the SAME NAME coming from a VARIETY OF SOURCES.

#### 2.4 Dangers involved in choosing a CHV

Head man: Very well, Dr.Sahib my sister will be your CHV

How much can she earn?

High Caste Group: It's a dirty job. This Harijan woman will do it.

She'll control food and medicines. If we chose ONE OF YOUR OWN, we'll gain control.

I have no abilities and people won't accept me.

Source : Training Village Health Workers - VHAI

### 3. Training

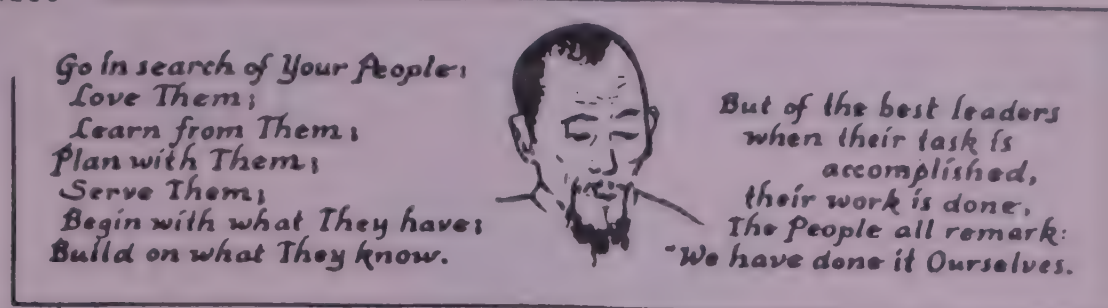
- the basic principles of training have been mentioned in the chapter on training and supervision.
- for further ideas how to train village level workers - CHV Consult :



Helping Health Workers learn by David Werner and Bill Bower.

AS YOU TRAIN CHV'S - REMEMBER THAT A FUND OF KNOWLEDGE ALREADY EXISTS  
THE COMMUNITY

IN



USE THE FORWARD BY LALANBAI TO ENCOURAGE YOUR CHVS.

an old Chinese verse:

Examples of specific time tables are given for your guidance.

#### Explanations for DIADS

The group is divided into pairs. Each pair spends 10 minutes (ten minutes) getting to know each other. The group then reassembles and each person introduces his / her partner to the group.

#### INCENTIVES FOR TRAINING:

Consider paying an incentive (usually the daily wage) to the CHV's transport allowance, when you call them for training.

#### 4. Support

Since the CHV is the main link of the programme with the community - SUCCESS OF YOUR PROGRAMME depends on adequate support of the CHV.

THE COMMUNITY HEALTH VOLUNTEER REQUIRES THE SUPPORT OF THE COMMUNITY AND THE HEALTH TEAM.

#### COMMUNITY SUPPORT:

One point is very clear. The Village Health Worker needs the support of the village community including the support of some of the powerful people in the village. Though she gives special attention to the needs of the poor, the support of the poor of the village alone will not be sufficient. Usually, the question of active community support comes only when they need help.

For example:

Immunization Campaigns-different village leaders will help by encouraging the people to take the dose by:

Settling disputes and misunderstandings by

- Interviewing and Explaining (not in capitals) - e.g. a mother complaining that the child was well before immunisation but fell sick afterwards



help in handling of Mischief makers e.g. the objection of an old women to the CHV being from the Harijan community .

Community health volunteers are human beings - they do make mistakes, they have many things on their minds, including the difficulties of their own family affairs. They do become distracted and they need support, especially when some incident arise from their own behaviour - an action or failure to act.

#### A CASE IN POINT

One Community Health Volunteer told us of a pregnancy case she had been following. The woman was in labour and our CHV had checked on her and reassured her several times the night before, but knew that she was not likely to deliver until morning. In the morning when she got up, she forgot about the woman and went to look after the feeding programme. During that time, someone else delivered the woman and she was quite angry that she had been forgotten in her hour of need. She told everyone: "Every time she put her hands on my abdomen, my pains vanished.

The local leaders told the people that this could not be true, scolded the woman and relieved the CHV of the anxiety of future trouble that belief in the woman's story would have caused.



#### HEALTH TEAM SUPPORT:

- it is EXTREMELY IMPORTANT for you and the field supervisors to support the CHV in the daily activities.

REMEMBER THAT PEOPLE IN THE COMMUNITY WILL OFTEN WANT YOUR, that is "THE LEADERS" ADVICE RATHER THAN THE CHV's. do not contradict or correct any advice the chv gives - IN THE PRESENCE OF THE COMMUNITY.

- visit her in the community as often as you can - not only in connection with her work but also "socially".



- continuing education based on actual situations she has encountered in accomplishing her tasks also helps support and encourage the CHV.
- solving with her any problems related to her work.
- include her in planning for specific programmes in the community for eg. - immunization programme.
- praising the CHV in the presence of others.

#### Malnourshed child

- support provided knowledge to recognise the signs of malnutrition, praise, appropriate advice given.

#### Family planning

- knowledge about methods of spacing; praise for each "acceptor"

#### Immunization

- knowledge about diseases which can be prevented. Praise for successful immunization.

One of your CHVs has identified a woman whom she believes to be a high risk mother needing special care - on further questioning you discover she has not comprehended the facts about exactly who is a high risk mother. You reprimand her in front of the mother and ask her to "review for herself the lesson on care of pregnant mother".

#### Example of good support:

During an under-five's clinic at a sub-centre a mother asks you to advise her on what kind of milk she should buy for her 3 month old baby - you turn to the CHV and ask her to explain to the mother the advantages of breast milk. You support everything she says and encourage the mother to follow the CHVs advice.

# SUGGESTED TIME-TABLE FOR CHVs

		With alternatives		Total time 12 hrs			
9:00 - 11:00 a.m		11:00 to 11:15	11:15 to 1:00	1:00 to 2:00	2:00 to 3:15 p.m	3:15 to 3:30	3:30 p.m to 5.30 p.m
DAY 1	SELF INTRODUCTION DIADS		Orientation to CBPHC programme		Orientation to training		Definition and struc- ture of a community
DAY 2	LEADERSHIP PATTERNS POWER AND CONFLICT CUSTOM AND BELIEFS AND THEIR RELEVANCE FOR CNPHCA		PROBLEMS OF TECHNOLOGY TRANSFER (understanding of change and adoption form)		RAPPORT BUILDING PROFILING COMMU- NITY CONCEPT OF PARTICIPATION PARTICIPATIVE COMMUNITY ORGANI- SATION		ROLE - PLAY
DAY 3	SURVEY		Record keeping		PRACTICALS ON SURVEY METHODOLOGY AND RECORDING		
DAY 4	CARE OF PREGNANT				DISCUSSION OF WOMEN'S ISSUES		REVIEW OF CARE OF PREGNANT MOTHERS
DAY 5	DELIVERY		POST NATAL CARE		PREPARATION OF STERILE KIT		OBSERVATION OF A NORMAL DELIVERY IF POSSIBLE / REV
DAY 6	FAMILY PLANNING		POPULATION EDUCATION		DISCUSSION OF METHODS CONTRA- CEPTION		BELIEFS AND RUMOURS ON CONTRACEPTIVE METHOD DISCUSSION
DAY 7	TEMPORARY METHODS		PERMANENT METHODS		DISCUSSION METHODS ADVANTAGES		ON ROLE PLAY ON F.P. COUNSELLING
DAY 8	DIET DURING PREGNANCY		DIET DURING LACT- ATION		DEMONSTRATION OF PREPARATION OF LOW COST RECIPE		DISCUSSION ABOUT COST + DIET
DAY 9	BREAST FEEDING AND INFANT FEEDING		MALNUTRITION		DETECTION PRACTICAL SESSION ON USE OF ARM CIRCUM.TAPE		PREVENTION OF MALNUTRITION
DAY 10	DIARRHOEA CAUSES		ORT		DEMONSTRATION PRACTICE IN ORT PREPARATION		ROLE-LAY CHILD WITH DIARRHOEA CAUSES
DAY 11	IMMUNISATIONS				DISCUSSION		REVIEW
DAY 12	VIT A		FOOD SOURCES OF VIT A		PRACTICALS SESSIONS ON USE OF FLASH CARDS		



Alternatives: to the suggested timetable for CHVS.

\* alternatives are given because there is no one fool proof method for training of CHVS.

\* Each project must decide on the most suitable method depending on the local situation. In general it may be difficult for health workers to come for a full 2 weeks programme at one time.

\* Total number of hours required for teaching major topics are as follows:

Working in and with the community	... 14 hrs
The CBPHC Project organisation	... 3 1/2 hrs
Survey and Record keeping	... 7 hrs
Womens Health including antenatal Delivery and Postnatal	... 14 hrs
Child Health:	
Immunization	... 7 hrs
Nutrition	... 14 hrs
Vit A	... 3 1/2 hrs
Oral Rehydration	... 7 hrs
Family Planning	... 14 hrs
	-----
	84 hrs
	=====

\* you may elect to teach for one or two/days/week only (assure 7 hours - 1 day). This will stretch your training over 6-12 weeks. In between training periods CHVS may given assignments to get to know and survey theri communities and record their findings.

## MANAGEMENT INFORMATION SYSTEM

### (M I S)

#### MANAGEMENT:-

What is meant by management?

Management is 'getting things done'; Management is 'the way one behaves towards the others'; Management is 'a general human activity, a basic human behaviour directed towards achieving activity, a basic human behaviour directed towards achieving goals or to satisfy needs. Management is a continuous activity.

#### PHC MANAGEMENT: -

It is the way of organising and getting things done, the way of making use of manpower, money, materials and methods, in order to achieve the goal 'HFA by the year 2000 A.D.

#### MANAGEMENT ACTIVITIES:-

##### (1) OBSERVING: -

Observing the situation using tools, techniques and methods. This is one of the basic steps of managing any project.

##### (2) LOOKING FOR POSSIBLE IMPROVEMENT:-

This is another essential aspect of management. This includes identifying & defining problems or defects and looking for opportunities to improving the situation.

##### (3) ANALYSING:-

What should be done,  
By whom,  
How and when.

##### (4) INFLUENTIAL IDEA:-

Influencing the decision which had an impact in the situation.

##### (5) CHECKING IMPLEMENTATION:-

After implementing a change or improvement of the situation, it should be checked through feed back to assess the change.

INSHORT, the following are the major steps in a management process

##### (1) Recognition of a problem or opportunity

- (2) Define & develop alternative action
- (3) Decision making
- (4) Implementation
- (5) Control performance

Recognising a problem is a critical step. The management process can not get started unless there is awareness of the problem.

Communication/Information and Feedback system is a very essential aspect in identifying a problem; and man as an information processing animal is a basic factor of management.

#### CHARACTERISTICS OF MANAGEMENT:-

The following are the main characteristics of management process:-

- (1) Management is an activity, not a person or group of persons.
- (2) Management is purposeful, and make things happen.
- (3) It is an accomplishment by, through and with people.
- (4) It is aided by, not replaced by a computer.
- (5) Management is not an exclusive property of the people at the top; for good management of PHC and its success, the community itself has to take part (community participation).

In PHC, the most important part is the people themselves. Therefore gaining people's confidence & support is an integral part of good management. If there is no communication with the people, the concept of involving the people in PHC will not work. Sharing with people and giving them a change to feel that they are part of the system gives them a sense of responsibility and they become interested.

People should be encouraged to identify their health/social problems; and involved in the solution of problems. Local leadership (teachers, elders, etc.) should be used to the fullest to get active participation.

INTERSECTORAL PARTICIAPTION:- i.e. involving other agencies (govt./non govt.) is also part of good management.

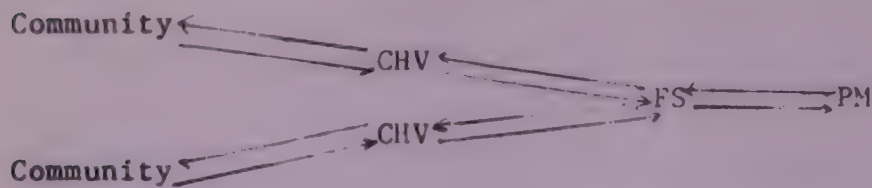
#### Management of PHC:-

Who is in charge (manager) in the management of PHC?

In the management of PHC even the people are in charge because they are also involved in the management.



The chain of 'Managers' in PHC may be shown as below:-

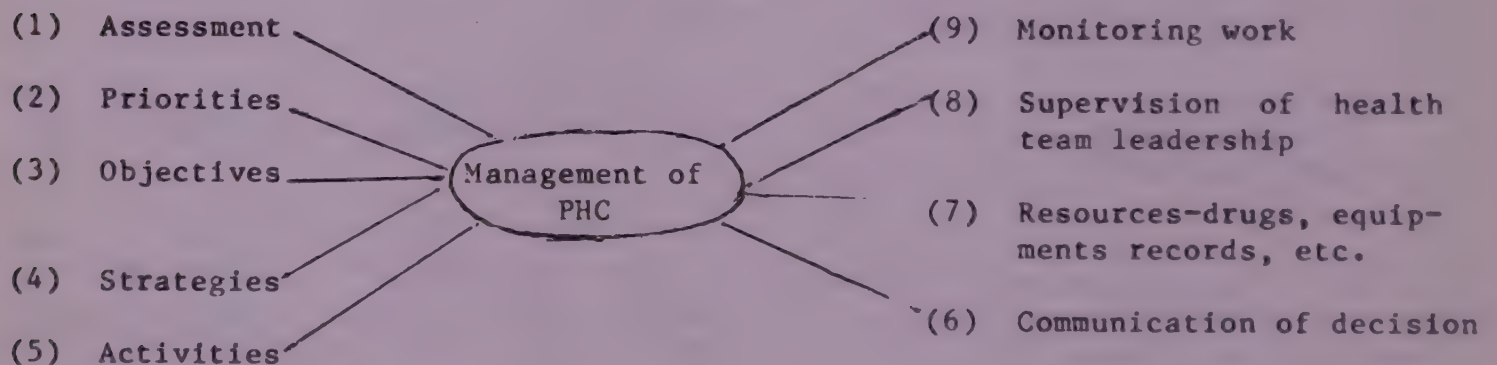


The most important element is the people themselves since they are involved in giving and receiving services. So it is also important how they interact, how they perform their tasks and how they solve their problems, etc.

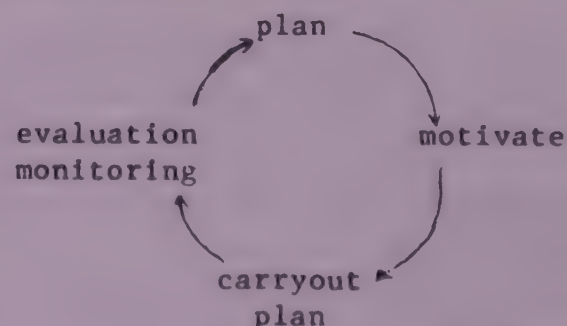
To know these, it is also important that an information system is developed between the people and others involved in the management.

A manager may be authoritative type (exploiting/benevolent) or consultative type, or participative type. But it is the participative type of management we should have in PHC because community's participation is very essential. So the manager at the community level (CHV) has to share with the people the PHC programmes, involve them in decision making and planning and invite suggestions from them for problem solving.

The various vital techniques involved in the management of PHC are as follows:



The general methods of management:-



Planning: Steps

- what objectives
- what background information
- how to achieve
- what activities
- requirements
  - money
  - method, etc

### Motivation: Steps

- information, background knowledge to staff
- invite comments and suggestions
- training staff
- modify plans, etc.

### Carry out plan: Steps

- Work plan
- fix starting date
- methodology
- staff training
- obtain equipments, money, etc.

### Evaluation : Steps

- fix time for evaluation
- have achieved objectives?
- what defects?
- what corrective action?
- how to solve problem?

### Leadership:

One of the important aspects of management is leadership. Humanistic approach is very essential in management especially at the higher levels. Honesty, dedication, sincerity, and commitment on the part of the leader will motivate those under him.

## HEALTH INFORMATION SYSTEM

### Conceptual aspects of Health Information system:-

#### Definition:

An 'Information system' is defined as an organization of people, machines and methods interacting to provide needed information in the right format, to the right people, at the right time, to support managerial or technical tasks (WHO).

Information system is an important part of CBPHC system. It is an essential element of the managerial process for the health development. It is basically a reporting and feedback system. The overall purpose of an information system is to make the right kind of information available at the right time, for the right person so that he can take the right decision. Information/data received must be interpreted at that level and the decisions made must be transmitted to the others so that appropriate action is taken.

Why is an Information system needed?

#### Purpose of Information System:-

Information system is basically a means to improve programme management. So



the main reason for having an Information system is to provide enough informations at every level for enabling the managerial performances and functions at that level. Therefore the report reaching each level must be appropriate and of the right kind, relevant to the functions performed at that level. In other words, the information should be useful for the receiver to perform his duties and functions better.

The Information System is needed for the following purposes:-

- (1) Monitoring health care at individual, family and community level:-
  - periodic observation of selected health problems (FIONA), activities and services, results, etc.
- (2) To compare the observed results with those expected in order to assess the success of the programme.
- (3) To detect the discrepancies and causes of failures.
- (4) To influence decision making levels so that betterment is made for the future.

So informations are required to assess progress and impact of the programme, as well as to carry out evaluation of the programme. By these means one can know the reason for success or failure of the programme. Monitoring is possible right from the start of the implementation of the programme, but evaluation can not be done at the beginning since it is too early. Monitoring is done at the community level and so the methodology for monitoring should be usable at that level.

Monitoring is for assessing the impact and progress of the programme, but evaluation is for analysing the activities with the purpose of identifying successful aspects of the programme as well as any deficiencies that are amenable to corrective action. So evaluation is to review and revise the programme.

Scope, needs and coverage of Information System:-

The amount of information needed will depend on the following :-

- (1) The level of the user
- (2) The functions expected at the user's level.
- (3) The stated objectives in relation to health service activities.

Only those informations which are going to be used to serve the purpose, which are going to affect a decision or action should be recorded and reported to another level of health management.

(a) At the PHC level:-

The most important stage at which information gets generated is at the community level where contact between the CHV and people is made. So the grass root level volunteers CHV should be told the scope of information at that level, including the quality, timeliness, ways of presentation, etc.



And this level the informations should cover those regarding individuals and families in relation to their health needs and the health services provided. These informations have to be provided by the people and the grassroots level volunteers, and so the recording system at this level has to be simple enough. The CHV has to be ensured of the proper stocks, supplies, help, guidance, etc. from the next higher level (F.S.)

(b) At Field Supervisors's level:-

The F.S. has to monitor and control the activities of the CHVs under him. He has to ensure timely supplies of stocks, provide help, guidance and support to CHVs to ensure good quality and quantity of work from them. Therefore, he should get informations to assess performances of each CHV in the various activities and to compare with the performances of other CHV under him. This will enable him to identify those who are doing good job, areas of defect, assess reasons of failure, take steps to motivate them, etc. The FS is also responsible for sending his reports to the Project Manager (PM). So he should collect adequate informations through the workers' report, records and discussions with them, in addition through on-the-spot checks.

(c) P.M. level:

The P.M. has to ensure a smooth going of the whole project. He has to focus on all aspects; has to monitor and control the works through the F.S.; has to maintain supplies, money etc; assess the two or more F.S. under him.

He should get all the informations needed for the above functions through the F.S.'s reports and feedback as well as through his own personal assessments.

He in addition has to give feedback informations to the F.S. for making any changes, improvements, etc. He is also responsible to report to the department of C.H. of the CMAI through CEO. So the informations he receives should be useful for performing this activity as well.

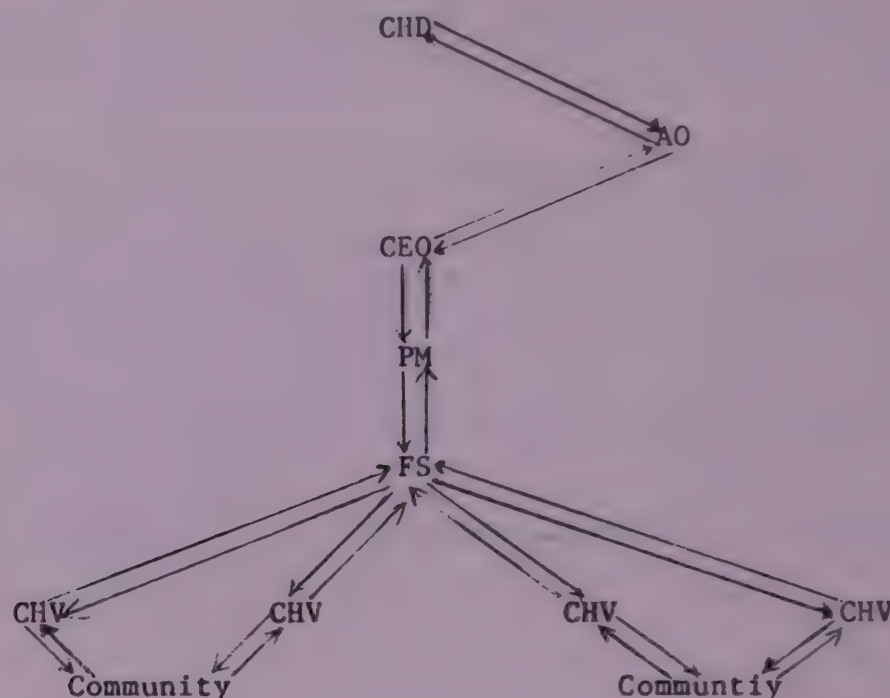
(d) At the department of (CH) level:-

The department controls the overall performance of all micro projects under CMAI's support. The informations received should be useful for making comparisons of different projects in order to identify area of defect, good performance, etc. These informations will be utilized for guiding the projects for future betterment.

The department (through the Area Offices) is responsible for giving guidance, support, as well as for monitoring the financial aspect of the projects.

So it is evident that there is need for adequate and relevant information system at each managerial level.

The flow-chart shows the information support system



#### Reporting system:-

The reporting system follows the upward direction in the flow chart - i.e.

CHV → FS → PM → CHD

#### Providers of information in a Community Based Project:-

It is important to decide who will provide information at each level. This will also help to decide what data to be collected and how to be collected.

- |                                   |   |
|-----------------------------------|---|
| (1) Community                     | <ul style="list-style-type: none"> <li>- individual - seeking help</li> <li>- leaders - teachers</li> <li>- religious leaders</li> <li>- etc.</li> </ul>              |
|                                   | - CHV   |
| (2) Health personnel in the area  | <ul style="list-style-type: none"> <li>- F.S.</li> <li>- P.M.</li> <li>- Govt. Staff</li> <li>- Private Staff</li> <li>- Other health teams.</li> </ul>               |
| (3) Local community organizations | <ul style="list-style-type: none"> <li>- welfare organization</li> <li>- women's group</li> <li>- youth club</li> <li>- other voluntary organization, etc.</li> </ul> |



### Sources of Information:-

Apart from the human resources mentioned above (providers), there are other sources of information as follows:-

#### (1) Records

These are documents of services provided and of resources such as drugs, supplies, money, etc. Duplication of efforts can be avoided by maintaining records. Health Care records are very important in PHC programmes for management purposes. Through records the location and identity of persons served, quantity and quality of services provided, outcomes of services, etc. can be elicited.

#### (2) Reports on work performed:-

The CHV may send his report to the F.S. wherever possible (this may apply only to literate volunteers who are capable of writing a report). But the F.S. should be able to extract a report from the records of the CHV. This will enable him/her to give a feedback immediately.

The F.S. should also consolidate the data from all/volunteers under him/her.

#### (3) Surveys:

Surveys are conducted as and when needed to get informations which can not be obtained from routine health care records.

#### (4) Registers:

These are official recording of items, names, actions, etc. (eg. list of individuals treated). Informations listed in register need not be repeated elsewhere.

#### (5) Adhoc reporting of emergency problems:

Immediate and personal reporting of an information when required. (eg. about an epidemic). This is usually to the next supervisor level for taking action or for appropriate referral service.

### Presentation of Information:

Whatever may be the source used for communicating an information, its presentation is very important for its effective utilization in day to day operational activities and at the decision making levels.

- Should be clear, simple, understandable, applicable and problem oriented.
- should facilitate decision making at each level.
- presentation may be in the form of tables, graphs, etc. or may be even verbal.



- same information can be presented in different ways for different users. (eg: at lower levels only raw data are reported but to send to higher levels the data must be analysed and the patterns/trends are reported rather than just raw data).

#### Feedback information:-

Feedback is an essential aspect of any information system. This is necessary at each level (eg. from FS to CHV from CHV to community, etc).

- feedback informations help the workers to analyse and modify their performances and activities.
- feedback informations are necessary for referred cases so that the worker who referred the case will know the diagnosis, treatment given as well as the follow up instructions - all of which are essential in proper care of the individual.
- if the worker knows that this informations are used by his superior, he is motivated to collect, record and report informations properly and in time in future.
- it must be remembered that feedback informations must be timely and appropriate if they have to serve the purpose.
- feedback at community level also is important. Regular feedback to community through Village Health committee or community groups will enable the people to know about their own health status. This will motivate them to take part in health promotion activities.

#### Types of health informations:-

The major types of PHC informations are:-

- (1) Informations regarding individuals and families in relation to their health needs.
- (2) Information for managerial purposes - this includes informations regarding productivity of different health units and personnel, resources, financial analysis and supplies such as sdrugs.
- (3) Informations on health indicators and other statisticl measurements useful for assessing the health status of the community.
- (4) Scientific informations related to PHC needs as obtained from health literatures and other sources.

In short, the I.S. can be classified as 3 main categories, namely,

- (1) Programme management information system,
- (2) Administrative and finance information system, and
- (3) Health information system

### Items of Information:-

The selection of items for information will depend upon their use and the level at which they will be used (central, intermediate or community level).

In CBPHC programme, the essential items should include the following:-

#### (1) Basic informations:-

- Social, cultural, geographical, environmental and economic factors.
- Population data.
- Data on target groups such as married women of reproductive age group, children aged 0-2 years, etc.

#### (2) Vital statistics:

- Health status of the community in the form of morbidity and mortality such as IMR, CBR, CDR, MMR, morbidity/mortality due to Diarrhoeal Diseases and EPI target diseases, morbidity due to nutritional problems, etc.

These items will help decision making while implementing programme in order to change them.

#### (3) Health Service Performances:-

- informations regarding coverage of health services (eg. AN coverage, FP coverage, immunization coverage. )

#### (4) Organisational structure including staff unit.

#### (5) Constraints and difficulties encountered while implementing.

### Content of Information:-

The content of information is as important as the item. The content describes precisely what is to be collected, how much, etc. (eg. IMR how much). This will help to set specific objectives for a programme. The content will vary from programme to programme. basically the content should cover the targets, specific objectives and activities, etc. of the programme.

### How to decide on the content?

This will depend on the needs and requirements of the programme. For example, for the CBPHC project. FIONA related informations must form the essential contents.

The other factors which will determine the content include space, time, organizational structure, resources, etc.

The contents should be user-oriented and relevant in order to enable in monitoring the services/activities.



It should also provide timely reliable information to influence decision making and planning.

The contents of information as well as the frequency with which they should be transmitted can only be determined through proper communication between users (eg: PM) and providers (eg:CHV).

Each level of staff structure must have clearly defined function as to what information is to be transmitted from that level or what information to be received and processed at that level - eg: type of data to be collected, type of indicators to be produced, analysed, reported,. etc.

#### At Community/CHV level:

The data collected at community level are primarily for providing services. So the contents of information required must be accurate but simple, since the CHV has to deal with recording/reporting at this level.

- must be understandable by them and acceptable, not over burdening.
- priorities (FIONA) must be made clear to them, there must be uniformity in the required informations and data - otherwise there will be conflict between the reports of different workers.
- one CHV will be responsible for about 1000 population. So the contents of informations he should transmit to the F.S. will be regarding the health needs of 1000 population at individual/family level in relation to FIONA.

eg: information on target population (eligible couples, 0-2 yr. children etc); needs of services (FP,AN,immunization, ORT, etc); and information (verbal or written) on services performed.

#### AT F.S. level:

The contents of information the Field Supervisor has to transmit to his Superior (PM) should cover FIONA informations of about 5000 population. He/she is also responsible for 5 CHVs and therefore his reports to the PM should include individual CHV's performances, areas of success and failures, etc - all in a comprehensive way. The information should also include each activity performed at subcentre level (eg.: AN coverage, FP coverage, Immunization coverage, etc.).

#### At P.M.'s level:

The PM need not have to report on individual activities or performance of each CHV. So the contents of information transmitted by him CHV should be the total performance of the project (eg: total achievements such as FP,Immunization coverages by all CHVs.)

In additon, the PM should receive informations on money and other supplies.



### At Area office level:

The Area Office should receive information from the Project Manager through CEO. The PDOs who are responsible for the project analyse these information and give appropriate feed back to PM through CEO.

### At C.H. department level:

The department should receive comprehensive informations of all microprojects from the project Managers. These should include overall informations on activities, inputs, achievements, failures, status of supplies and budget.

### Elements (components) of I.S.

The following are the 5 essential elements of information system:-

#### (1) Data collection:-

Collecting data is one of the elements in obtaining information. There could be many methods to elicit information at household/community level, such as,

- using questionnaire/interviewing
  - individuals
  - groups
  - leaders
- direct observations and measurements
- data obtained from sources such as CHVs hospital records, special surveys, other agencies, etc.

While selecting a data collection method, one has to remember that the data so collected must be easy to record and analyse, should be precise and reliable, and of low cost. Data gathering is done only for description of variable in programme operation and not to identify problems (i.e. not to interpret the data).

Each programme should have facilities to store the data. Storage is usually centralised. This makes it easy for retrieval whenever required.

#### (3) Data processing and analysis:

Processing of available data is done mainly to compare the achieved objective to those expected; also for comparing similar activities. Processing and analysis of data are usually done at Central level where the data is stored. The processing will involve many steps - editing, coding, classifying, compiling, tabulating and interpretation. Computer may be used for data processing. The interpretations are dispersed from Central levels (PM and CHD).

(4) Management and control:-

This includes directing, managing and controlling the whole system, and providing for co-ordination among the subsystems.

(5) Transmission/Dissemination:-

Information is needed both at the Community level as well as the decision making level. So it has to be systematically provided as and when required.

The dissemination may be in response to special information needs such as sending a monthly report to PM, or may be in the form of publications of academic interest.

How to select data, record, report and process

This will depend on the functions and purposes of each level. The information system in this respect may be described as a pyramidal structure as below:-

PM/CHD	Information Resources for planning & decision making.
FS/PM	Information Resources to aid in decision making & planning
FS	Information resources for day to day operational management.
CHV	Informations on health status of the community, services rendered etc.

At the basic level the data are collected mainly for giving essential health services in relation to FIONA. So the data to be collected should be so designed that they are easy and simple for CHV to carry out. They should be focussed on FIONA and only the relevant informations are passed on to the FS's level.

Informations generated and transmitted from higher levels (F.S./PM) should be such that they aid in influencing the decision making level above them.

Indicators for Information

Indicators for PHC are instruments used to monitor and assess the level of activities, achievements of objectives, and outcome of the programme in terms of change in health status of people.

Indicators for monitoring are used at the time of execution of activities, whereas those for evaluation are used periodically (eg: annually).

### Selection/formulation of indicators:-

Before selecting and formulating the indicators, one has to first define the activities to be monitored and the outcomes to be achieved.

A good indicator must be,

- (1) Valid - should actually measure what it is supposed to measure,
- (2) Sensitive - to changing situations
- (3) Specific - to particular situation or phenomenon only
- (4) Simple and
- (5) Feasible

Some indicators (eg:IMR,MMR,etc) have to be calculated using available numerators and denominators. The description of numerator /denominator will determine the type of data to be collected and processed for calculating the indicator. If it is feasible to collect these data, it means that the particular indicator can be selected.

### Some of the indicators for feedback from the CHV are as follows:-

#### (1) Immunization:

- No. of vaccinations/month in 0-2 year age group (DPT, Polio, etc).
- No. of cases of EPI target diseases (measles, Diphtheria, pertussis, etc) per month, etc.

#### (2) MCH

- No. of deliveries conducted by trained/untrained dais/month
- No. of AN attendance/month
- No. of TT injections for pregnant women/month

#### (3) FP

- No. of FP acceptors/month
- No. of UCDs inserted/month
- No. of O.C. packets distributed,
- etc.

#### (4) ORT:-

- No. of children (0-2 yrs) who had DD in one month
- No. of deaths due to DD
- No. of ORS packets used
- etc.

#### (5) Vit. A

- No. of Vit. A supplementary doses given/month
- No. of children with night blindness,
- etc.



This F.S. can assess the percentage performance of each CHVs using the above indicators, compare, and identify who is doing a good job, who needs better motivation, etc.

The F.S. while sending his/her report, should use indicators which will enable the PM to assess the overall performance of all 5 CHVs under one F.S. For example, the F.S.'s report could be in a format as below:-

Items of Information	Name of CHVs					Total
	A	B	C	D	E	
No. of villages						
No. of population						
No. visited/month						
No. of DPT doses						
No. of Polio doses						
No. of BCG doses						
No. of Measles doses						
No. of AN cases						
No. of TT given						
No. of IUDs used						
No. of Vit A. supp.						
etc						

The Project Managers report should use indicators which will represent a cumulative performance of the whole project under him.

Eg.

Immunization

Month	DPT				Polio				TT		etc.
	1	2	3	BD	1	2	3	BD	1	2	
Jan											
Feb.											
March											
Total											

M C H

Month	ANC	Deliveries			
		Home		Hosp.	Total
		Trained	Untrained		
		Dais	Dais		
Jan.					
Feb.					
March					
Cum.					

Nutrition

Month	Iron/FA		Vit.A	
	Mother	0-2 yrs	Mother	0-2 yrs
Jan				
Feb.				
March				
Cum.				

F.P.

Month	Vs	TBS	IUD	O.C.	Condom	CC
Jan						
Feb.						
March						
Cum.						

Vital Statistics:-

Birth		T	Death		T	Infnt deaths		Maternal deaths	D.D (0-2yr)
						0-1yr	0-1mth		
M	F		M	F		M	F	M	F
Month									
Cum.									

From the informations thus obtained from the PM's report, the department of Community Health of CMAI can calculate indicators such as IMR,MMR,CBR,CDR, percentage performances of various FIONA related activities, etc.

Development/Establishment of a health information system in CBPHC:-

The development of an information system is a continuous process, and should be carried out from the very first step of the programme as a collaborative undertaking between all levels of providers/users of the system.

The various points to consider are:-

- (a) The development of the system should first consider the user's needs (user-orientation ).

The system should be comparable with other similar systems of the organization (organization-wide uniformity) . For example, the informations collected/obtained from different CBPHC microproject must be comparable,because they need to be collated, stored in standard formats, processed and disseminated by CMAI according to needs.



Different levels have different requirements. Therefore the system should be developed in such a way that only the informations required by the other levels are transmitted to that level.

(b) For the development of the information system, it is essential that contacts between the various staff units involved must be well established,

- contacts between CHV and community
- contacts between CHV and FS.
- contacts among different higher levels (FS, PM, CEO, CHD)

These contacts will ensure regular transmission of informations between them through proper communication channels.

(c) It is also necessary that those concerned with the information system must be adequately motivated to record, report, process, etc.

(d) Proper supervision, and timely appropriate feedbacks are other essential factors for successful establishment of an information system.

(e) Internal reporting system is an essential element in the overall information system.

Regular, formal reporting between each levels regarding the programme activities and achievements will enable to assess the progress of the project.

The first report should include all baseline informations, whereas the subsequent ones will include mainly the updating of the relevant data, various service activities vital events and achievements.

The periodicity of reporting will vary with the level of the user. At basic level (CHV) it should be a continuous (daily/weekly) reporting process; but at the PM/CHD level it will be periodic (monthly, annual, etc).

(f) Profile of the system:

At village level, informations on health situation (FIONA) of the people should be the main area of concern.

The indicators used should be simple and usable by the CHV. The informations should in addition include those of other basic factors such as population data, family size, etc as well as those of the activities performed by each volunteer. Translation of information may required at this level.

Feedback to and from the people also is important at this level. It should be a participatory type of communication between the CHV and community; the feedback from the community will be particularly useful in modifying programmes for the future.

At the subcentre/F.S.'s level - It is more or less a collaborative type of information generated and transmitted - i.e., covering activities and achievements in all villages under the responsibility of the particular F.S. (performance of 5 CHVs).

At the PM,s and department of CH level also the informations are the collaborative types covering one whole project, and all microprojects respectively.

(g) Referral System is also part of information system for giving adequate health care to the individuals covered by the CBPHC project. While referring, information has to be provided indicating the reason for referral, to whom, from whom, etc. Similarly, feedback information from the referral centre to the referring worker/FS is also important, showing the diagnosis, treatment given, further follow up instructions, etc - all treatment given, further follow up instructions, etc - all of which are essential in providing good services to the individuals.

Responsibilities of the CH department in MIS:

- (1) Organization, monitoring and supervision of CBPHC records/reports.
- (2) Collation and processing/analysis of data sent by project Managers for,
  - reporting to higher levels of administration (CH committee of CMAI),
  - providing regular timely feedback to Area Managers of CMAI and to peripheral levels,
  - responding to special requests/needs at CBPHC levels.  
(eg: special informations, organization of surveys, etc.)
- (3) Regular timely supply of recording forms and other information materials.
- (4) Provision of storage facilities for forms, etc.
- (5) Provision of facilities for the display of feedback information and health education materials.
- (6) Regular supervision and evaluation
  - The Area office will check regularly that the data are collected and reported from the peripheral levels as required.
  - The Area office will also see that facilities for training, supplies, storage, etc are satisfactory.
  - Observing the trends in health status and taking appropriate action at Area Office level.
  - Keeping in touch with the CBPHC level supervisors to give encouragement and advice and to disseminate information through them to the CHVs.



### Use of Records in Health Care delivery:-

Records are one of the sources informations and they are important for management purposes. Records are documents of services given, the outcomes, resources, etc.

- Record maintenance is mainly to improve quality of services, especially in cases where continuing care is given. One should be able to know by going through the record, what has been done in the past, what results so far, etc.
- Practice of having one record per individual permits efficiency as well as confidentiality.
- Records also contain informations for extracting statistical reports and for health survey.
- Records serve as tools for supervision. By reviewing the records the supervisor can assess the health care given to the individuals. The supervisor can also give necessary education/motivation to the CHV by indicating his approval or otherwise of the records.
- The supervisor must make sure that the CHV enters the data correctly.
- The records must be standardised so that there will be uniformity between the reports of different workers.
- The terms used must also be standardised - in case the workers can only give verbal informations in local language, then some standard terms must be taught initially. These verbal informations must then be put in records by the F.S.
- During his weekly visits, the F.S. can enter data into his dairy/records.

### Some of the recommended records and registers for CBPHC are:-

- (1) Family Folder
- (2) MWRA card
- (3) Child Health (under:2) card
- (4) AN (Mother) card
- (5) Clinic Register

The Family Folder will give a quick reference on all family members, especially if there is an EC, AN or under 2 child, etc with reference to their respective numbers.

The child health card will give reference on the child`s health, vaccination status, etc. The Mothers card will give details on the status of the mother`s health, pregnancy, condition of the baby at birth, etc. Similarly the MWRA will refer to the FP methods accepted, change of method if any, reason, complications, etc.

All cards will have reference number of the Family Folder which in turn will have numbers of other cards, if any.



Survey register

(eg. FP survey)

Sl. No :

House No:

Name/address

Age:

Husband:

Wife:

No. of living children: M: F:

Age of last living child:

Pregnant: YES/NO

FP adopted YES/NO

If yes, which method:

If no, willing for YES/NO

Which method:

## Management of FP Programme in the field:

What is your target population?

18% of your population will be eligible couples i.e couple in whom the women is in the age 15 to menopause.

30% of the eligible couples will be using some form of contraception. This percentage is called couple protection rate.

Your target will be all the eligible couples who are not practising some form of contraception.

Criteria for selection of couples for use of the different methods.

### SELECTION OF COUPLES FOR CONTRACEPTIVE METHODS

In advising a couple as to the most suitable method of contraception to be used by them, the following factors should be taken into consideration.

1. The age of the couple.
2. The health of the couple.
3. The number of pregnancies the woman has had.
4. The number of living children.
5. The health of the children.
6. The sex of the children.
7. The age of the youngest child.
8. The availability of the services, viz., personnel, supplies and follow-up.
9. Whether the couple wish to space their children or limit the size of their family.
10. The preference of the couple for a particular method.
11. The facilities available in the home, e.g., privacy, water supply and facilities for storage of contraceptives.
12. The cost involved in purchasing contraceptives or in travel to the place of free supply.
13. Specific family situations, e.g., either partner refuses to use any method, irresponsibility of either partner, long absence or chronic illness of either partner.
14. The presence of medical contraindications to the use of a particular method especially the IUCD or the pill. This could be determined after history taking and medical examination at the clinic.

REMEMBER THE FOLLOWING.

FOR TEMPORARY METHODS:

SELECT COUPLES WITH ONE OR TWO LIVING CHILDREN

EMPHASISE THE ADVANTAGES OF SPACING

## PROCUREMENT OF SUPPLIES

There are two sources from which you can procure your family planning supplies for the project.

### (1) Government Sources,

The Director of Health services and family welfare is responsible to supply all the commodities relating to family planning in that state under his jurisdiction through the District Health Office and Primary Health Centres.

### (2) From Local Markets

Commodities are available in the local market but the project has to buy it for their supply in the community.



## How to organise ante-natal services for your project

How can you estimate the number of pregnant women in your area?

This is derived from the birth rate - 30 - 40/1000 population.  
So on an average there will be approximately 350 pregnant women in your project area (out of 10000 population).

Pregnancy lasts for 9 months.

Hence  $\frac{3}{4}$ th of the 350 women can be expected to be pregnant.

Studies have shown  $\frac{1}{4}$ th of the pregnant attended clinic only after 2 - 3 months.

So you are left with another 50% pregnant women who if well motivated will use the ante-natal services.

Your target should be 100% in these women.

Usually 20% of the women who come for first visit drop out.

In the rest there is a high risk of 20% pregnant women.

With the above facts in mind set up your ante-natal services.

### Supplies

Equipment:- suggestions are -

- essential furniture at subcentre (examination table)
- weighting scales - adults + children preferably one portable Height measuring scale (can be improvise by marking on the wall).
- Home visiting kit bags containing BP apparatus, and portable weighing scale.
- containers for collecting urine.
- test tubes for testing urine.
- Equipment for measuring Hemoglobin (check with your hospital lab which will be most suitable for use at the sub centre.)
- equipment for administering medicines.
- Thermometers - oral and rectal
- Syringes & needles/check with your hospital nursing section.
- Bowls and kidney bags check with your hospital nursing section for this.
- Registers and Record forms

- Expendable supplies

A) Drugs:

1) Iron and Folate tablets

Each pregnant women will need approx 100 tablets during her course of pregnancy.

Calculate and stock these for your project.

These tablets can be obtained from DHO free of cost. Consult your hospital & pharmacy for further guidance.

2) Tetanus Toxoid Injection:

Each pregnant woman needs minimum of 2 ml of Tetanus toxoid during her pregnancy (minimum 2 dose of 1 ml each Intramuscular 4 weeks apart)

Available as multidose vials and single dose ampoules.

Consult your hospital pharmacy before ordering/purchase.

This may be obtained from DHO office. Contact DHO directly

3) Multivitamin tablets:

Keep minimum stock of these tablets

4) Contraceptives

B. Surgical gloves

C. Matches and fuel

D. Toilet soap

E. Health Education materials - Flash cards Flip charts

OPTIONAL:

1. Mackintosh

2. Hand towels

3. Surgical instruments

4. Black board

How to conduct an immunization programme in the field level, calculate your requirements, e.g. BCG 210 x 2 = 420 doses you need

How do you procure vaccines?

Vaccines can be obtained from different sources like:

- (1) From Government
- (2) From other agencies
- (3) From local drug distributors.

The district health office provides vaccines like BCG, DPT and Oral Polio free of cost. There must be 25% reserve of

To obtain this you will have to follow the procedures laid down by the government and submit reports regularly to the DHO office. Try to utilise this. Calculate your vaccine requirements

Other agencies like Rotary Club provide vaccines. Contact these sources.

The local drug distributors can supply vaccines. You will have to spend money for these vaccines.

IF YOU ARE SPENDING MONEY ON PROCURING VACCINES, BUY MEASLES VACCINE.

Consult your hospital pharmacy before procuring vaccines

How much vaccine will you need?

For a population of 10000 there will be approximately 350 children newly born in a year.

Assume you expect a coverage of 60%.

Number of children to be covered are 210.

So you need	BCG	1 dose x 210	= 210 doses.
	DPT	3 dose x 210	= 630 doses.
	OPV	3 dose x 210	= 630 doses.
	Measles	1 dose x 210	= 210 doses.

Wastage rate for vaccines:

BCG	2
OPV	1.33
DPT	1.33
Measles	2



Calculate your requirement including the wastage rate.  
e.g. BCG  $210 \times 2 = 420$  doses you need in a year.

Frequency of Supply:

Assume you collect supplies every month you will need:

$420/12 = 35$  doses of BCG.

Reserve

There must be 25% reserve stock at any time i.e.

$35 \text{ doses} \times 1.25 = 44 \text{ doses}$

Calculate your vaccine requirements for each vaccine

## VACCINE STORAGE AND TRANSPORT

### 1. How do you store vaccine?

#### ALL VACCINES MUST BE

- 1) STORED AT A TEMPERATURE WITHIN THE RANGE PRESCRIBED BY THE MANUFACTURER
- 11) PROTECTED FROM SUNLIGHT
- 111) PREVENTIVE FROM CONTACT WITH ANTESEPTIC SOLUTIONS LIKE SPIRIT.

Vaccine should be kept in the thermacool containers in subcentres during use.

DISCORD ALL UNUSED BCG, POLIO AND MEASLES VACCINES AT THE END OF THE WORKING DAY BECAUSE THEIR POTENCY IS LOST RAPIDLY WHEN NOT REFRIGERATED.

#### For mothers

Pregnant mothers are 4% of the population.

So for 10000 population 400 pregnant mothers will be there.

The figures are rough estimates, calculate for your area, based on actual survey figures.

What are the potential problems you may come across?

#### (1) Power failure affecting storage:

Plan ahead of time for the eventuality of power failure, i.e. plan to store the vaccine in a place where generator is available.

#### (2) Labels of vaccine:

Labels are liable to fall off. To prevent this apply adhesive tape (plaster) and label the vial.

#### (3) Disease Epidemics:

If you hear of many children having measles in and around your project area try to obtain measles vaccine as soon as possible and immunize as many under 5 as possible.

(4) If there are many children in the community with polio, do not give any intramuscular injection including DPT vaccine.

(5) If you are thinking of buying vaccines. Think of MEASLES VACCINE. Other vaccine can be obtained free of cost, without too much difficulty.

## 2. How do you transport vaccine?

Remember the maintenance of "cold chain" is important even during transport of vaccines.

"IMPOTENT VACCINES ARE USLESS". Use thermacool as containers with cool packs these are available in the market. These cool packs can be frozen and kept in side thermo cool containers with vaccines.

## HOW TO RUN AN IMMUNIZATION PROGRAMME?

The children in the project area can be immunized either:

- (i) During pulse immunization programmes.
- (ii) In regular child health clinics held at Sub Centres.

Remember that regular stock and supply of vaccines should be made available for Health clinic pulse immunization. No child which has come to receive immunization should go back, because of non-availability of vaccines.

## 3. Where do you procure vaccine?

OPT, OPV, TT vaccines are available with the DHO, free of cost, provided you submit reports to the Government in their proforma.

Measles vaccines is not available from the Government. But Voluntary organisations like Rotary club sometimes provide these vaccines.



## SHELF - LIFE & STORAGE OF VACCINE

MEASELES	ORAL POLIO	DPT	TETANUS	BCG
2 years in freezer	2 years in freezer	1 1/2 years in the middle shelf of the refrigerator	1 1/2 years in the middle shelf of the refrigerator	8 month in the middle shelf of the refrigerator

FREEZING DPT, TT OR BCG CAUSES  
PRECIPITATION

### SHELF LIFE:

If a vaccine is carefully stored at the right temperature it should work for about two years. This is its shelf life - the time it can stay on the shelves of a refrigerator. If it becomes warm, its life is much shorter. If you look on a box of vaccine you will see a date printed. This is the expiry date. It shows the end of the shelf life and it is the date when a properly stored vaccine expires or becomes useless. Don't use vaccines after the expiry date.

## STORY TELLING

### Janaki and Saraswati: a story from India

Once upon a time, not long ago, there was a young health worker named Janaki, who lived in a small village called Mumabundo in northern India. After making a list of the health problems in her village, Janaki realised that one of the biggest problems was that women did not eat well during pregnancy. They ate too little, and were very thin and anemic. As a result, many babies were born small, thin, and weak. Many of them died. Some of the mothers died too, from bleeding or infection following childbirth.

Janaki began to call pregnant women together on Tuesday afternoons to teach them about nutrition. She explained the different food groups and the importance of getting enough to eat. She told the women about vitamins and minerals, and which foods contained iron that would prevent them becoming anemic. To make the meetings more interesting, Janaki used flash cards and a flannel-board, and even had the mothers bringing different foods from their gardens and the market.

But as the months went by, nothing changed. One night, one of the mothers who had regularly attended the Tuesday meetings gave birth. She had become more and more anemic during pregnancy, and from the loss of blood following childbirth, she died. Her baby died, too.

Janaki felt partly to blame. She decided to go talk to Saraswati a wise old woman whom everyone went to for advice. Saraswati also practiced ayurvedic medicine - the traditional form of healing.

Janaki explained her problem to the old women.

Saraswati put her wrinkled hand on Janaki's shoulder. "I think your problem is this, she said, you started with what you were taught in your health training instead with what the women in the village already know. You must learn to see things through their eyes.

"What do you mean? asked Janaki.

"You have been telling the women that eating more during pregnancy will make their babies weigh more at birth. But mothers here are afraid to have big babies. Sometimes, if a baby is too big for her hips, the mother cannot give birth so women have learned to eat little during pregnancy, in order to have smaller babies.

No wonder my teaching failed. "Why didn't they tell me? I tried to encourage to express their ideas.

"Maybe you spoke your own ideas too quickly and too strongly," said Saraswati, "the women do not like to contradict you."

"Then how can I teach them? asked Janaki.



"Begin with what they know and believe. Build on that," answered Saraswati. "For example, talk to them about dhatu. According to our tradition, dhatu is a substance that brings strength and harmony. It is related to eating certain foods. Pregnant women are not interested in gaining weight or having large babies. But they are interested in strength and harmony for themselves and their babies, and this comes through dhatu."

Janaki invited Saraswati to come to talk with the women about dhatu at the next Tuesday meeting.

When everyone had gathered, Saraswati started by telling a story about a family whose mango crop failed because they did not fertilize their trees in time. She asked, "Near the time of harvest, if the fruit looks weak, is that the time to think of adding manure to the ground. "Oh no," said the women. "It is too late."

"So it is with giving birth," said Saraswati. "A difficult birth is often caused by weakness of the mother and child, because they lack dhatu. Since a mother must share her dhatu with her child, she needs to eat plenty of dhatu-producing foods. But dhatu takes time to be made. Foods that make blood and dhatu need to be eaten all through pregnancy."

The following Tuesday Saraswati did not go to the meeting. But before it began, she talked to Janaki about ways that Janaki might interest the mothers in eating foods with iron. Saraswati reminded her that redness of the body and blood is considered a sign of health. In Mumabundo, pregnant women are said to be in danger of 'impurities of the blood' and iron is traditionally used to protect and purify the blood in times of danger. Also, teas made from iron-rich plants like fenugreek and sesame are given to girls when they begin to menstruate and before they marry to strengthen blood and increase beauty. Saraswati suggested that Janaki build on these traditions to help the women realize the need for iron-rich foods during pregnancy.

So Janaki discussed these customs during the Tuesday meeting. "When one of us is 'impure' during menstruation or after childbirth, or when lightning flashes, or someone has fits, we hold a piece of iron in our hands or throw it in front of the house. Why is that? It is to protect us from Sandhi - the evil spirits.

"When a chicken dies suddenly. We cook it with a piece of iron in the pot. Why? To purify it from visha 'poison'.

"Yes" said Janaki. "We all know iron has guna - the power to protect and purify. This is also true inside the body. Iron makes the blood red and strong. We can see by the red colour of our tongues and fingernails that our blood is strong. If the blood is weak, these are pale, not red.

The women began to examine each others tongues and fingernails. Soon they became concerned "some of us have very weak blood," they said. "We need guna to purify and protect us. Should we hold a piece of iron?"



"Iron will help", explained Janaki, "but only when it is inside us. There are plants that are rich in iron. What plants do we give in tea to girls when they begin to have monthly bleeding, or before marriage, to increase their blood and beauty?"

"Fenugreek and sesame seed," said the women.

"Yes," said Janaki, "These plants are rich in iron. We should eat them during pregnancy, to strengthen our blood."

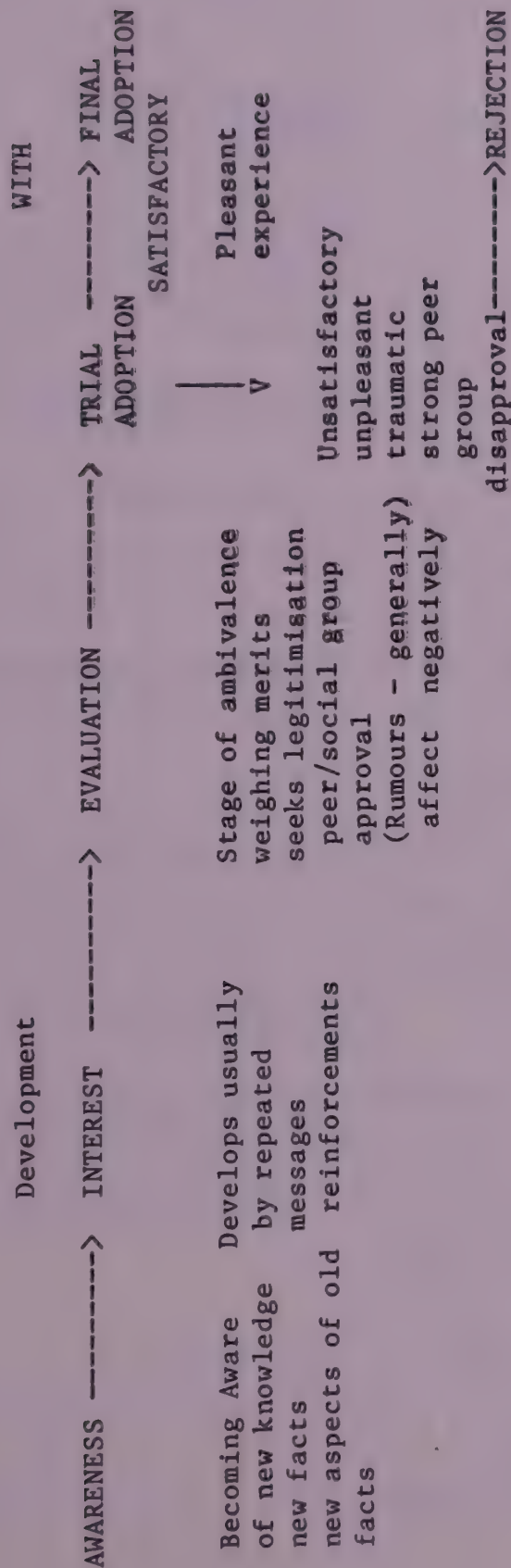
"What other foods are rich in iron?" the mothers asked eagerly. Janaki had already told them many times. But this was the first time they had shown real interest and asked for the information themselves.

As the weeks and months went by, more and more women came to the Tuesday discussions. Each week they examined each others tongues and fingernails. And changes began to take place. They had discovered that the guna in the iron-rich foods strengthened their blood. They also had begun to eat more so that they and their babies, through dhatu, would gain more strength and harmony.

Today, eating well during pregnancy has become part of the tradition in Mumabando. Babies are born healthier, and fewer women die in childbirth.

Exercise: Analyse this story and identify the important points or methods that enhance the effectiveness of the message.

# DISTINCTIVE STAGES INVOLVED IN THE ADOPTION PROCESS



MASS MEDIA APPROACH

---

SMALL GROUP INTERACTION AND PERSONALISED APPROACH

---

PERSONALISED ENCOURAGEMENT  
PROBLEM SOLVING  
VALUE BASED REWARDS

Maslows stage of meeting  
"Tertiary Needs"

# Advantages and disadvantages of certain teaching methods and of different educational media

Advantages	Disadvantages
1. Lectures:	
(1) Apparent saving of time (for the teacher) and resources.	1. Keeps the students in a passive situation.
(2) Presence of the teacher (showmanship)	2. Does not facilitate learning how to solve problems.
(3) Covers a large group of students.	3. Offers hardly any possibility of checking.
(4) Gives a feeling of security.	4. Does not allow for individual pace of learning.
	5. Low receptivity
2. Small group activities:	
(1) Permits a teacher/student dialogue (thanks to the availability of the teacher)	1. High costs in personnel and time unless peer-teaching is used)
(2) Facilities evaluation	
3. Practical work	4. Beside teaching
	5. Field work
1. Puts the student in an active situation.	1. High personnel, transport and material cost.
2. Covers a limited group of students.	2. Sometimes put the patient in a difficult situation.
3. Permits evaluation of degree to which educational objectives (practical and communication skills) have been attained	3. Poor standardisation.
4. Develops qualities of observation and decision taking.	
5. Ensures closer contact with reality (professional health situation of country, colleagues and teachers.)	



6. Permits comparison between practice and theory.

7. Enables student to develop self-confidence.

8. Increases variability.

6. Books, handouts, programmed learning from books, and simulation (self learning packages)

---

1. Enables student to work at his own pace.

1. Necessitates special educational competence

2. Facilitates self-evaluation.

2. High additional investment costs (in teachers time and money)

3. Makes mass teaching possible with high efficiency

3. No group dynamics.

4. High availability.

5. Facilitates decision-taking (solution of complex problems)

6. Reduces risks (for patient or society)

7. Avoids bias transmitted by 'bad teachers'

8. Allows a good teacher to save time that can then be spent on more complex activities such as interpersonal relations.

9. Can be kept up to date with new scientific developing and contain references to other documents.

7. Real objects and specimens:

1. Present reality, not substitutes,
2. Three dimensional
3. Permit use of all senses in study.

1. May not be easily obtainable.
2. Inconvenience of size - danger in use
3. Costly or not expendable.
4. Usually only usable in small groups
5. Sometimes easily damaged.
6. Problems in storage.

---

8. Models and simulation devices.

1. Three dimensional and concept of reality
2. Size allows close examination
3. Good for magnified situation
4. Can be used to demonstrate function as well as construction.

1. Craftsmanship required for local construction
2. Simulation models often expensive .
3. Usable for small groups.

- |   |  |
|---|--|
| 5. Can permit learning and practice of  | 4. Models often easily damaged.  |
|   | 5. Never same as performing technique on a patient. Beware of faulty learning. |
| 6. Some can be made with local material |  |
- 

9. Graphics charts, diagrams, schematic drawings), posters, paintings, photographic prints.

- |  |  |
|--|--|
| 1. Promote correlation of information.                             | 1. For small audiences only (unless projected with epidiascope).           |
| 2. Assist organisation of material                                 | 2. For effective use, good duplicating equipment and trained staff needed. |
| 3. Photographs nearer to reality than drawings,                    |  |
| 4. Usually easily produced and duplicated (black and white photos) |  |
| 5. Easy to store, catalogue and retrieve,                          |  |
- 

10. Blackboard or flipchart

- |  |   |
|--|---|
| 1. Inexpensive, can be made locally                                      | 1. Back to audience   |
| 2. Usable for wide range of graphic                                      | 2. Audience limited to 50 or so.  |
| 3. Allows step-by-step build up, or organisation of structure or concept | 3. Careful drawings erased, not preserved for future use, except in the case of flipcharts. |
- 

11. Flannelboard (Flannelgraph). Most of the comments apply also to magnetic board

- |   |   |
|---|---|
| 1. May be used repeatedly.                              | 1. For limited audience only.               |
| 2. Usually preparable from locally available materials. | 2. Difficult technique to use convincingly. |
| 3. Good for showing changing relationships.             |   |
| 4. Holds attention if well used.                        |   |
| 5. Can be adapted for group participation.              |   |

## PROJECTABLE MEDIA

### 12. Still pictures - opaque projection (Epidiascope)

- |  |   |
|--|---|
| 1. Enlargement of drawn or printed materials for large audiences.        | 1. Demands total darkness for clear projection (except with very expensive models). |
| 2. Obviate need for producing slides and transparencie                   | 2. Bulky machine, difficult to transport.   |
| 3. Enlarged image may be transferred to chart or blackboard for copying. | 3. Electricity required.  |
| 4. Small objects and specimens may be projected.                         |   |
- 

### 13. Transparencies for overhead projection.

- |  |   |
|--|---|
| 1. Projectable in full day light to large audiences                        | 1. Electricity required.  |
| 2. Presented facing audience   | 2. Equipment and materials for making sophisticated transparencies expensive                                    |
| 3. Relatively easy to prepare with local materials                         | 3. Not usually suitable for photographic material due to cost (although adaptor available to take 35 mm slides) |
| 4. Subjects can be drawn in advance or developed by stages with the group. | 4. Usually restricted to teacher use, as it is not easy to adapt for the learner to use.                        |

### 14. Slides and film strips

- |  |  |
|--|--|
| 1. Suitable for large audiences.                                     | 1. Fixed order of frames in filmstrip restrictive in use.                        |
| 2. Relatively easy production and (in black and white) reproduction. | 2. Need partial darkness for viewing unless rear screen or daylight screen used. |
| 3. Cheapest current forms of visual medium                           | 3. Duplication of colour slides expensive (even impossible in many countries)    |



4. Easily adptable to self-learning packages.

5. Equipment available for viewing or projection without electricity source.

#### 15. Microfilms

1. Easy storage and cataloguing of large numbers of visuals.

2. Exchange of information on available collections.

3. Very cheap per image if projection can be asured for large groups.

4. Small and light for easy despatch.

#### 16. Films 8 mm and 16 mm

1. Close to reality with movement and sound

2. Suitable for large audience (16mm)  
for small groups only (8 mm)

3. Compression of time and space.

4. Emotive, can develop attitudes, pose problems, demonstrative skills.

5. 8 mm loops useful for individual instruction

6. Good learning source if preceded by teacher`s introduction and followed by discussion.

1. Too small for clear naked-eye viewing.

2. Although inexpensive equipment available for individual use large group projection equipment not readily available.

1. Does not permit self-pacing

2. Films costly and difficult to produce.

3. Individual films relatively expensive.

4. Electricity required.

5. Equipment difficult to transport

6. Darkness needed for viewing except rear screen use)

7. Imported film may contain inappropriate information (see item in advantage 6).

## LIST OF RESOURCE MATERIAL USED TO PREPARE THIS MANUAL

1. Analysis of the situation of children in India.
  - UNICEF.
2. A community Hand Book for Developing Countries.
  - Judith E. Brown
  - Richard C. Brown
3. Central Bureau of Health intelligence.
  - Ministry of Health G.O.I.
4. Contact
  - Various issues.
5. Child Survival how it works.
  - Seeds
6. Diarrhoea Dialogue
  - Various issues.
7. Educational Hand Book for Health Personnel.
  - J.J. Guilbert.
8. Future
  - UNICEF.
9. Health Statistics of India 1985.
  - G.O.I.
10. Helping Health Workers Learn.
  - David Werner
  - Bill Bower
11. Hand Book for the Delivery of Care to Mothers And Children in a Community Development Block.
  - Dr (Mrs) H. Dhillon
  - Miss S. Dasgupta
  - Dr. M.K. Krishna Menon
  - Dr. P.M. Shah
12. Health Care in India.
  - George Joseph
  - John Desrochers
  - Mariamma Kalathil
13. Hand Book for Family Planning Field Workers.
  - IPPF
14. Information for action issue paper (Growth Monitoring)
  - UNICEF
15. Manual for Field Workers.
  - UNICEF
16. Manual for Female Health Workers Volume 1 & 2.
  - Ministry of Health G.O.I.
17. National Nutrition Monitoring Bureau, 1980.
  - National Institute of Nutrition

18. On Being In charge - WHO 1980.
19. Primary Child Care A Manual for health workers.
  - Maurice King
  - Felicity King
  - Soebagio Martodpoero
20. Revised Strategy for National Family Welfare Programme.
  - Ministry of Health G.O.I. (1986)
21. The Foundation for Research in Community Health, Bombay.
22. The State of the Worlds Children 1985.
  - UNICEF
23. Towards Universal Immunization 1990.
  - Ministry of Health G.O.I.
24. Teaching for better learning.
  - F.R. Abbat
25. Teaching Guide for Training of Village Health Workers.
  - Patriciaf Wakehaur
26. Teaching Village Health Workers.
  - Ruth Harnar
27. Taking Sides.
  - Sathyamala & others
28. Where There is No Doctor.
  - David Werner
29. Working together for Health.
  - TAFTEE (1984)
30. Bharkat Narain, Swash Hind 1961
31. Parke's Text Book of Preventive and Social Medicine.
32. Hulbe 1980 - Approached to Rural Development.
33. Development by the N.L.L. in the Philippines in Guidelines for Development : CCA, 1980
34. Health for All - ICSSR & ICMR publication.
35. Health for the millions-June 1987.

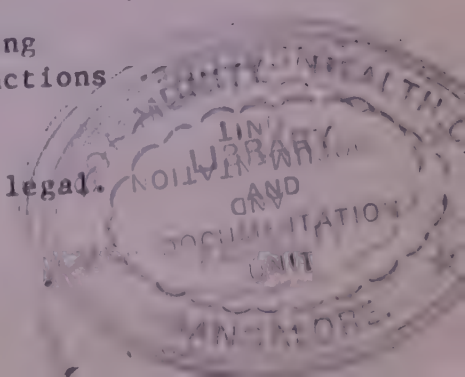


## LIST OF WORD MEANINGS

WORD	MEANING
1 Abscess	A small collection of pus.
2 Ablution	A cleansing or washing.
3 Ailments	Diseases
4 Ambivalence	Possessing ability of equal power or value in two directions.
5 Anaemia	Less blood.
6 Antenatal	Occurring before birth.
7 Anthropometry	Science of measuring the human body and its parts and functional capacities.
8 Anus	The outlet of the rectum.
9 Appetite	Desire especially for food; not necessarily hungry.
10 Assimilate	To absorb digested food.
11 Augment	To add to or increase.
12 Bronchopneumonia	Inflammation of the terminal bronchioles and alveoli.
13 Bruise	An injury in which skin is discolored but not broken .
14 Callous	Hard like a callus.
15 Castrated	Desexed; emasculated.
16 Chronic	Long drawn out; applied to a disease that is not acute.
17 Clustred	Jammed together.
18 Coax	Encourage.

19	Concomitant	Accesssory taking place at the same time.
20	Conjunctiva	Mucous membrane which lines eyelids and is reflected onto eyeball.
21	Contraction	A shrotening,
22	Contrast	Showing striking differences.
23	Convulsion	Paroxysms of involuntary muscular contraction and relaxations generally in children.
24	Curative	Tending to cure
25	Disseminating	Scattered over a considerable area.
26	Empowered	Authorise, License.
27	Encompassing	Surround
28	Epidemic	Appearance of an infectious disease not of local origin which attacks many people at the same time in the same area.
29	Epilepsy	An episodic disturbance of conciousness in which generalized convulsion may occur.
30	Ethnic	Language.
31	Excreta	Waste intestinal matter; feces.
32	Fang	A sharp pointed tooth; the root of a tooth.
33	Fastidium	Aversion to food or to eating.
34	Filarisis	A chronic disease due to one of the filariae.
35	Foetus	Growing baby in the womb.

36	Foster	Affectionately, Cherish
37	Gastroenteritis	Inflammation of the stomach and bowels.
38	Gauze	Thin, transparent fabric used in surgery.
39	Hepatitis	Inflammation of the liver.
40	Hormones	A chemical substance originating in an organ, gland or part, which is conveyed through the blood to another part of the body, stimulating it to increased functional activity, and increased secretion.
41	Hypertension	High blood pressure.
42	Ignorance	Want of knowledge.
43	Impotent	Unable to Copulate.
44	Incessantly	Unceasing, continual,
45	Infant	0 to 1 year old child.
46	Inhalation	Act of drawing in of breath, vapor, or gas into the lungs; inspiration.
47	Innovative	Bring in novelties;
48	Intensity	A high degree of activity.
49	Intramuscular	Inside a muscle.
50	Intrinsic	Inherent; belonging to a part.
51	Lactating	The period of sucking in mammals. The functions of secreting milk.
52	Legitimacy	Condition of being legal.





53	Maiming	To injure seriously.
54	Marasmus	Emaciation, wasting.
55	Masculinity	Having male characteristics.
56	Meningitis	Inflammation of the membranes of spinal cord or brain.
57	Migraine	Periodic pain in one side of the head accompanied by disordered vision, nausea.
58	Morbidity	State of being diseased.
59	Mortality	Death
60	Mucous	Having the nature of or resembling mucus.
61	Multisectional	Many sections
62	Node	A knot, knob, protuberance or swelling.
63	Norm	Custom, tradition
64	Nourishment	Act of nourishing, or of being nourished.
65	Nucleus	A central point about which matter is gathered as in a calculus.
66	Obese	Extremely fat.
67	Oedema	Swelling.
68	Ovary	One of the two glands in the female, producing the reproductive cell, the ovum, and female sex organs.
69	Paediatrician	Child specialist.
70	Pallor	Lack of color; paleness.

71	Peripheral	Located at or pertaining to the periphery.
72	Pitting	The formation of pits or depressions .
73	Prophylaxis	Observance of rules necessary to prevent disease.
74	Pulmonary	Disease of lungs.
75	Ragged	Irregular.
76	Rampant	Out of control.
77	Rapport	A relationship of sympathy and confidence.
78	Recanalization	Again formation of channels in tissue.
79	Rigidity	Tenseness, immovability.
80	Shin	leg between the ankle and knee.
81	Sibling	One of 2 or more children of same parents.
82	Sore	Causing physical pain.
83	Spermatozoa	Male eggs.
84	Spilling	An overflow.
85	Spinal	Pertaining to the spine or spinal cord.
86	Sprouted	Germinated.
87	Starvation	The condition of being without food for a long period of time.
88	Symptoms	Any perceptible change in the body or its functions which indicates disease.
89	Testicles	The two ovoid male gonads.



90 Trauma	An injury or a wound.
91 Triceps	A muscle of the arm.
92 Tubal	Pertaining to a tube especially the fallopian tube.
93 Tubectomy	Cutting and removing a portion of the fallopian tube.
94 Tuberculosis	Diseases affecting most tissues of the body marked by tubercles.
95 Umbilical	umbilicus
96 Vasectomy	Removal of all or a segment of the vas deferens
97 Vial	A small glass bottle for medicines or chemicals.
98 Vulnerable	Easily injured.
99 Xerophthalmia	Conjunctival dryness, in diseases due to deficiency of Vitamin A

